STATE OF COLORADO CONTRACT MODIFICATION
CONTRACT AMENDMENT #1

State Agency
Department of Health Care Policy and Financing
Contractor
Rocky Mountain Health Maintenance Organization, Inc
Original Contract Number
25-196884
Amendment Contract Number
25-196884A1

Contract Performance Beginning Date
The Effective Date
Current Contract Expiration Date
06/30/2026
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.

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
Patrick Gordon

DocuSigned by:
35A5356F969D46D...

Date: 06/30/2025 | 12:06 PDT

STATE OF COLORADO
Jared S. Polis, Governor
Department of Health Care Policy and Financing
Kim Bimestefer, Executive Director

DocuSigned by:
0B6A84797EA8493...

Date: 06/30/2025 | 13:10 MDT

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD
Department of Health Care Policy and Financing
Jerrod Cotosman, Controller

DocuSigned by:
Jerrod Cotosman
76F69541272B43A...

Amendment Effective Date: 06/30/2025 | 13:16 MDT

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

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

1. 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.

2. 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 or Month Day, Year, whichever is later and shall terminate on the termination of the Contract or Month Day, Year, whichever is earlier.

4. PURPOSE

The purpose of this Amendment is to update Exhibit O – HB21-1289 Implementation to reflect revised program implementation requirements and timelines in alignment with current operational and policy directives. Additionally, this Amendment updates the Rates Exhibit to incorporate the most recent rate methodologies and payment terms applicable to services provided under the Regional Accountable Entity (RAE) contract.

5. MODIFICATIONS

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

1. 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.
2. 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.
3. Exhibit C, Payment is hereby deleted in its entirety and replaced with Exhibit C-1, Payment, attached. All references to Exhibit C, Payment shall henceforth be a reference to Exhibit C-1, Payment.

4. Exhibit O, HB21-1289 Implementation is hereby deleted in its entirety and replaced with Exhibit O-1, HB21-1289 Implementation, attached. All references to Exhibit O, HB21-1289 Implementation shall henceforth be a reference to Exhibit O-1, HB21-1289 Implementation.

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.

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CONTRACT PROVISIONS

1. PARTIES

This Contract is entered into by and between Contractor named on the Cover Page for this Contract ("Contractor"), and the STATE OF COLORADO acting by and through the State agency named on the Cover Page for this Contract (the "State," the "Department," or "HCPF"). Contractor and the State agree to the terms and conditions in this Contract.

2. TERM AND EFFECTIVE DATE

A. Effective Date

This Contract shall not be valid or enforceable until the Effective Date. The State shall not be bound by any provision of this Contract before the Effective Date and shall have no obligation to pay Contractor for any Work performed or expense incurred before the Effective Date or after the expiration or sooner termination of this Contract.

B. Initial Term

The Parties' respective performances under this Contract shall commence on the Contract Performance Beginning Date shown on the Cover Page for this Contract and shall terminate on the Initial Contract Expiration Date shown on the Cover Page for this Contract (the "Initial Term") unless sooner terminated or further extended in accordance with the terms of this Contract.

C. Extension Terms - State's Option

The State, at its discretion, shall have the option to extend the performance under this Contract beyond the Initial Term for a period, or for successive periods, of one year or less at the same rates and under the same terms specified in the Contract (each such period an "Extension Term"). In order to exercise this option, the State shall provide written notice to Contractor in a form substantially equivalent to the Sample Option Letter attached to this Contract. Except as stated in **§2.D**, the total duration of this Contract, including the exercise of any options to extend, shall not exceed seven years from its Effective Date absent prior approval from the Chief Procurement Officer in accordance with the Colorado Procurement Code.

D. End of Term Extension

If this Contract approaches the end of its Initial Term, or any Extension Term then in place, the State, at its discretion, upon written notice to Contractor as provided in **§14**, may unilaterally extend such Initial Term or Extension Term for a period not to exceed two months (an "End of Term Extension"), regardless of whether additional Extension Terms are available or not. The provisions of this Contract in effect when such notice is given shall remain in effect during the End of Term Extension. The End of Term Extension shall automatically terminate upon execution of a replacement contract or modification extending the total term of this Contract.

E. Early Termination in the Public Interest

The State is entering into this Contract to serve the public interest of the State of Colorado as determined by its Governor, General Assembly, or Courts. If this Contract ceases to further the public interest of the State, the State, in its discretion, may terminate this

Contract in whole or in part. A determination that this Contract should be terminated in the public interest shall not be equivalent to a State right to terminate for convenience. This subsection shall not apply to a termination of this Contract by the State for Breach of Contract by Contractor, which shall be governed by **§12.A.i**.

i. Method and Content

The State shall notify Contractor of such termination in accordance with **§14**. The notice shall specify the effective date of the termination and whether it affects all or a portion of this Contract, and shall include, to the extent practicable, the public interest justification for the termination.

ii. Obligations and Rights

Upon receipt of a termination notice for termination in the public interest, Contractor shall be subject to the rights and obligations set forth in **§12.A.i.a**.

iii. Payments

If the State terminates this Contract in the public interest, the State shall pay Contractor an amount equal to the percentage of the total reimbursement payable under this Contract that corresponds to the percentage of Work satisfactorily completed and accepted, as determined by the State, less payments previously made. Additionally, if this Contract is less than 60% completed, as determined by the State, the State may reimburse Contractor for a portion of actual out-of-pocket expenses, not otherwise reimbursed under this Contract, incurred by Contractor which are directly attributable to the uncompleted portion of Contractor's obligations, provided that the sum of any and all reimbursement shall not exceed the maximum amount payable to Contractor hereunder.

3. DEFINITIONS

The following terms shall be construed and interpreted as follows:

A. "**Breach of Contract**" means the failure of a Party to perform any of its obligations in accordance with this Contract, in whole or in part or in a timely or satisfactory manner. The institution of proceedings under any bankruptcy, insolvency, reorganization or similar law, by or against Contractor, or the appointment of a receiver or similar officer for Contractor or any of its property, which is not vacated or fully stayed within 30 days after the institution of such proceeding, shall also constitute a breach. If Contractor is debarred or suspended under §24-109-105, C.R.S. at any time during the term of this Contract, then such debarment or suspension shall constitute a breach.

B. "**Business Day**" means any day in which the State is open and conducting business, but shall not include Saturday, Sunday or any day on which the State observes one of the holidays listed in §24-11-101(1), C.R.S.

C. "**Chief Procurement Officer**" means the individual to whom the Executive Director has delegated his or her authority, pursuant to §24-102-202, C.R.S. to procure or supervise the procurement of all supplies and services needed by the State.

D. "**CJI**" means criminal justice information collected by criminal justice agencies needed for the performance of their authorized functions, including, without limitation, all information defined as criminal justice information by the U.S. Department of Justice, Federal Bureau

of Investigation, Criminal Justice Information Services Security Policy, as amended and all Criminal Justice Records as defined under §24-72-302, C.R.S.

E. "**Contract**" means this agreement, including all attached Exhibits, all documents incorporated by reference, all referenced statutes, rules and cited authorities, and any future modifications thereto.

F. "**Contract Funds**" means the funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Contract.

G. "**CORA**" means the Colorado Open Records Act, §§24-72-200.1, *et seq.*, C.R.S.

H. "**Deliverable**" means the outcome to be achieved or output to be provided, in the form of a tangible object or software that is produced as a result of Contractor's Work that is intended to be delivered to the State by Contractor.

I. "**Effective Date**" means the date on which this Contract is approved and signed by the Colorado State Controller or designee, as shown on the Signature Page for this Contract. If this Contract is for a Major Information Technology Project, as defined in §24-37.5-102(2.6), C.R.S., then the Effective Date of this Contract shall be the later of the date on which this Contract is approved and signed by the State's Chief Information Officer or authorized delegate or the date on which this Contract is approved and signed by the State Controller or authorized delegate, as shown on the Signature Page for this Contract.

J. "**End of Term Extension**" means the time period defined in **§2.D**.

K. "**Exhibits**" means the exhibits and attachments included with this Contract as shown on the Cover Page for this Contract.

L. "**Extension Term**" means the time period defined in **§2.C**.

M. "**Goods**" means any movable material acquired, produced, or delivered by Contractor as set forth in this Contract and shall include any movable material acquired, produced, or delivered by Contractor in connection with the Services.

N. "**Incident**" means any accidental or deliberate event that results in or constitutes an imminent threat of the unauthorized access, loss, disclosure, modification, disruption, or destruction of any communications or information resources of the State, which are included as part of the Work, as described in §§24-37.5-401, *et seq.,* C.R.S. Incidents include, without limitation, (i) successful attempts to gain unauthorized access to a State system or State Records regardless of where such information is located; (ii) unwanted disruption or denial of service; (iii) the unauthorized use of a State system for the processing or storage of data; or (iv) changes to State system hardware, firmware, or software characteristics without the State's knowledge, instruction, or consent.

O. "**Initial Term**" means the time period defined in **§2.B**.

P. "**Party**" means the State or Contractor, and "Parties" means both the State and Contractor.

Q. "**PCI**" means payment card information including any data related to credit card holders' names, credit card numbers, or other credit card information as may be protected by state or federal law.

R. "**PHI**" means 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.

S. "**PII**" means personally identifiable information including, without limitation, any information maintained by the State about an individual that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information. PII includes, but is not limited to, all information defined as personally identifiable information in §§24-72-501 and 24-73-101, C.R.S. "PII" shall also mean "personal identifying information" as set forth at § 24-74-102, et. seq., C.R.S.

T. "**Services**" means the services to be performed by Contractor as set forth in this Contract, and shall include any services to be rendered by Contractor in connection with the Goods.

U. "**State Confidential Information**" means any and all State Records not subject to disclosure under CORA. State Confidential Information shall include, but is not limited to, PII, PHI, PCI, Tax Information, CJI, and State personnel records not subject to disclosure under CORA. State Confidential Information shall not include information or data concerning individuals that is not deemed confidential but nevertheless belongs to the State, which has been communicated, furnished, or disclosed by the State to Contractor which (i) is subject to disclosure pursuant to CORA; (ii) is already known to Contractor without restrictions at the time of its disclosure to Contractor; (iii) is or subsequently becomes publicly available without breach of any obligation owed by Contractor to the State; (iv) is disclosed to Contractor, without confidentiality obligations, by a third party who has the right to disclose such information; or (v) was independently developed without reliance on any State Confidential Information.

V. "**State Fiscal Rules**" means the fiscal rules promulgated by the Colorado State Controller pursuant to §24-30-202(13)(a), C.R.S.

W. "**State Fiscal Year**" means a 12 month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in that calendar year.

X. "**State Records**" means any and all State data, information, and records, regardless of physical form, including, but not limited to, information subject to disclosure under CORA.

Y. "**Subcontractor**" means any third party engaged by Contractor to aid in performance of the Work.

Z. "**Tax Information**" means federal and State of Colorado tax information including, without limitation, federal and State tax returns, return information, and such other tax-related information as may be protected by federal and State law and regulation. Tax Information includes, but is not limited to all information defined as federal tax information in Internal Revenue Service Publication 1075.

AA. "**Work**" means the Goods delivered and Services performed pursuant to this Contract.

BB. "**Work Product**" means 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 material that was developed prior to the Effective Date that is used, without modification, in the performance of the Work.

Any other term used in this Contract that is defined in an Exhibit shall be construed and interpreted as defined in that Exhibit, including the terminology in Exhibit D.

4. STATEMENT OF WORK

A. Contractor shall complete the Work as described in this Contract and in accordance with the provisions of Exhibit B and Exhibit E. The State shall have no liability to compensate Contractor for the delivery of any goods or the performance of any services that are not specifically set forth in this Contract.

B. The State, at its discretion, shall have the option to increase or decrease the statewide quantity of Goods and Services based upon rates established in this Contract, and increase the maximum amount payable accordingly. In order to exercise this option, the State shall provide written notice to Contractor in a form substantially equivalent to the Sample Option Letter attached to this contract. Delivery of Goods and performance of Services shall continue at the same rates and terms as described in this Contract.

5. PAYMENTS TO CONTRACTOR

A. Maximum Amount

Payments to Contractor are limited to the unpaid, obligated balance of the Contract Funds. The State shall not pay Contractor any amount under this Contract that exceeds the Contract Maximum for that State Fiscal Year shown on the Cover Page for this Contract.

B. Payment Procedures

i. Invoices and Payment

a. The State shall pay Contractor in the amounts and in accordance with the schedule and other conditions set forth in Exhibit B, Statement of Work and Exhibit C, Payment.

b. Contractor shall initiate payment requests by invoice to the State, in a form and manner approved by the State.

c. The State shall pay each invoice within 45 days following the State's receipt of that invoice, so long as the amount invoiced correctly represents Work completed by Contractor and previously accepted by the State during the term that the invoice covers. If the State determines that the amount of any invoice is not correct, then Contractor shall make all changes necessary to correct that invoice.

d. The acceptance of an invoice shall not constitute acceptance of any Work performed or Deliverables provided under this Contract.

ii. Interest

Amounts not paid by the State within 45 days of the State's acceptance of the invoice shall bear interest on the unpaid balance beginning on the 45th day at the rate of 1% per month, as required by §24-30-202(24)(a), C.R.S., until paid in full; provided, however, that interest shall not accrue on unpaid amounts that the State disputes in writing. Contractor shall invoice the State separately for accrued interest on delinquent amounts, and the invoice shall reference the delinquent payment, the number of day's interest to be paid and the interest rate.

iii. Payment Disputes

If Contractor disputes any calculation, determination or amount of any payment, Contractor shall notify the State in writing of its dispute within 30 days following the earlier to occur of Contractor's receipt of the payment or notification of the determination or calculation of the payment by the State. The State will review the information presented by Contractor and may make changes to its determination based on this review. The calculation, determination or payment amount that results from the State's review shall not be subject to additional dispute under this subsection. No payment subject to a dispute under this subsection shall be due until after the State has concluded its review, and the State shall not pay any interest on any amount during the period it is subject to dispute under this subsection.

iv. Available Funds-Contingency-Termination

The State is prohibited by law from making commitments beyond the term of the current State Fiscal Year. Payment to Contractor beyond the current State Fiscal Year is contingent on the appropriation and continuing availability of Contract Funds in any subsequent year (as provided in the Colorado Special Provisions). If federal funds or funds from any other non-State funds constitute all or some of the Contract Funds the State's obligation to pay Contractor shall be contingent upon such non-State funding continuing to be made available for payment. Payments to be made pursuant to this Contract shall be made only from Contract Funds, and the State's liability for such payments shall be limited to the amount remaining of such Contract Funds. If State, federal or other funds are not appropriated, or otherwise become unavailable to fund this Contract, the State may, upon written notice, terminate this Contract, in whole or in part, without incurring further liability. The State shall, however, remain obligated to pay for Services and Goods that are delivered and accepted prior to the effective date of notice of termination, and this termination shall otherwise be treated as if this Contract were terminated in the public interest as described in **§2.E**.

6. REPORTING - NOTIFICATION

A. Quarterly Reports.

In addition to any reports required pursuant to this Contract or pursuant to any other Exhibit, for any contract having a term longer than three months, Contractor shall submit, on a quarterly basis, a written report specifying progress made for each specified performance measure and standard in this Contract. Such progress report shall be in accordance with the procedures developed and prescribed by the State. Progress reports shall be submitted to the State not later than five Business Days following the end of each calendar quarter or at such time as otherwise specified by the State.

B. Litigation Reporting

If Contractor is served with a pleading or other document in connection with an action before a court or other administrative decision making body, and such pleading or document relates to this Contract or may affect Contractor's ability to perform its obligations under this Contract, Contractor shall, within 10 days after being served, notify the State of such action and deliver copies of such pleading or document to the State's Principal Representative identified on the Cover Page for this Contract.

C. Performance Outside the State of Colorado or the United States, §24-102-206, C.R.S.

To the extent not previously disclosed in accordance with §24-102-206, C.R.S., Contractor shall provide written notice to the State, in accordance with **§14** and in a form designated by the State, within 20 days following the earlier to occur of Contractor's decision to perform Services outside of the State of Colorado or the United States, or its execution of an agreement with a Subcontractor to perform, Services outside the State of Colorado or the United States. Such notice shall specify the type of Services to be performed outside the State of Colorado or the United States and the reason why it is necessary or advantageous to perform such Services at such location or locations, and such notice shall be a public record. Knowing failure by Contractor to provide notice to the State under this section shall constitute a Breach of Contract. This section shall not apply if the Contract Funds include any federal funds.

7. CONTRACTOR RECORDS

A. Maintenance

Contractor shall maintain a file of all documents, records, communications, notes and other materials relating to the Work (the "Contractor Records"). Contractor Records shall include all documents, records, communications, notes and other materials maintained by Contractor that relate to any Work performed by Subcontractors, and Contractor shall maintain all records related to the Work performed by Subcontractors required to ensure proper performance of that Work. Contractor shall maintain Contractor Records until the last to occur of: **(i)** the date three years after the date this Contract expires or is terminated, **(ii)** final payment under this Contract is made, **(iii)** the resolution of any pending Contract matters, or **(iv)** if an audit is occurring, or Contractor has received notice that an audit is pending, the date such audit is completed and its findings have been resolved (the "Record Retention Period").

B. Inspection

Contractor shall permit the State, the federal government, and any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and transcribe Contractor Records during the Record Retention Period. Contractor shall make Contractor Records available during normal business hours at Contractor's office or place of business, or at other mutually agreed upon times or locations, upon no fewer than two Business Days' notice from the State, unless the State determines that a shorter period of notice, or no notice, is necessary to protect the interests of the State.

C. Monitoring

The State, the federal government, and any other duly authorized agent of a governmental agency, in its discretion, may monitor Contractor's performance of its obligations under this

Contract using procedures as determined by the State or that governmental entity. The State shall monitor Contractor's performance in a manner that does not unduly interfere with Contractor's performance of the Work.

D. Final Audit Report

Contractor shall promptly submit to the State a copy of any final audit report of an audit performed on Contractor's records that relates to or affects this Contract or the Work, whether the audit is conducted by Contractor or a third party.

8. CONFIDENTIAL INFORMATION-STATE RECORDS

A. Confidentiality

Contractor shall keep confidential, and cause all Subcontractors to keep confidential, all State Records, unless those State Records are publicly available. Contractor shall not, without prior written approval of the State, use, publish, copy, disclose to any third party, or permit the use by any third party of any State Records, except as otherwise stated in this Contract, permitted by law or approved in writing by the State. Contractor shall provide for the security of all State Confidential Information in accordance with all policies promulgated by the Colorado Office of Information Security and all applicable laws, rules, policies, publications, and guidelines. If Contractor or any of its Subcontractors will or may receive the following types of data, Contractor or its Subcontractors shall provide for the security of such data according to the following: **(i)** the most recently promulgated IRS Publication 1075 for all Tax Information and in accordance with the Safeguarding Requirements for Federal Tax Information attached to this Contract as an Exhibit, if applicable, **(ii)** the most recently updated PCI Data Security Standard from the PCI Security Standards Council for all PCI, **(iii)** the most recently issued version of the U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Security Policy for all CJI, and **(iv)** the federal Health Insurance Portability and Accountability Act for all PHI and the HIPAA Business Associate Agreement attached to this Contract, if applicable. Contractor shall immediately forward any request or demand for State Records to the State's Principal Representative.

B. Other Entity Access and Nondisclosure Agreements

Contractor may provide State Records to its agents, employees, assigns and Subcontractors as necessary to perform the Work, but shall restrict access to State Confidential Information to those agents, employees, assigns and Subcontractors who require access to perform their obligations under this Contract. Contractor shall ensure all such agents, employees, assigns, and Subcontractors sign agreements containing nondisclosure provisions at least as protective as those in this Contract, and that the nondisclosure provisions are in force at all times the agent, employee, assign or Subcontractor has access to any State Confidential Information. Contractor shall provide copies of those signed nondisclosure provisions to the State upon execution of the nondisclosure provisions if requested by the State.

C. Use, Security, and Retention

Contractor shall use, hold, and maintain State Confidential Information in compliance with any and all applicable laws and regulations only in facilities located within the United States, and shall maintain a secure environment that ensures confidentiality of all State Confidential Information. Contractor shall provide the State with access, subject to

Contractor's reasonable security requirements, for purposes of inspecting and monitoring access and use of State Confidential Information and evaluating security control effectiveness. Upon the expiration or termination of this Contract, Contractor shall return State Records provided to Contractor or destroy such State Records and certify to the State that it has done so, as directed by the State. If Contractor is prevented by law or regulation from returning or destroying State Confidential Information, Contractor warrants it will guarantee the confidentiality of, and cease to use, such State Confidential Information.

D. Incident Notice and Remediation

If Contractor becomes aware of any Incident, Contractor shall notify the State immediately and cooperate with the State regarding recovery, remediation, and the necessity to involve law enforcement, as determined by the State. Unless Contractor can establish that Contractor and its Subcontractors are not the cause or source of the Incident, Contractor shall be responsible for the cost of notifying each person who may have been impacted by the Incident. After an Incident, Contractor shall take steps to reduce the risk of incurring a similar type of Incident in the future as directed by the State, which may include, but is not limited to, developing and implementing a remediation plan that is approved by the State at no additional cost to the State. The State may adjust or direct modifications to this plan in its sole discretion, and Contractor shall make all modifications as directed by the State. If Contractor cannot produce its analysis and plan within the allotted time, the State, in its discretion, may perform such analysis and produce a remediation plan, and Contractor shall reimburse the State for the actual costs thereof. The State may, in its sole discretion and at Contractor's sole expense, require Contractor to engage the services of an independent, qualified, State-approved third party to conduct a security audit. Contractor shall provide the State with the results of such audit and evidence of Contractor's planned remediation in response to any negative findings.

E. Data Protection and Handling

Contractor shall ensure that all State Records and Work Product in the possession of Contractor or any Subcontractors are protected and handled in accordance with the requirements of this Contract, including the requirements of any Exhibits hereto, at all times.

F. Safeguarding PII

If Contractor or any of its Subcontractors will or may receive PII under this Contract, Contractor shall provide for the security of such PII, in a manner and form acceptable to the State, including, without limitation, State non-disclosure requirements, use of appropriate technology, security practices, computer access security, data access security, data storage encryption, data transmission encryption, security inspections, and audits. Contractor shall be a "Third-Party Service Provider" as defined in §24-73-103(1)(i), C.R.S. and shall maintain security procedures and practices consistent with §§24-73-101 *et seq.*, C.R.S. In addition, as set forth in § 24-74-102, et. seq., C.R.S., Contractor, including, but not limited to, Contractor's employees, agents and Subcontractors, agrees not to share any PII with any third parties for the purpose of investigating for, participating in, cooperating with, or assisting with Federal immigration enforcement. If Contractor is given direct access to any State databases containing PII, Contractor shall execute, on behalf of itself and its employees, the certification attached hereto as Exhibit H on an annual basis Contractor's duty and obligation to certify as set forth in Exhibit H shall continue as long as Contractor

has direct access to any State databases containing PII. If Contractor uses any Subcontractors to perform services requiring direct access to State databases containing PII, Contractor shall require such Subcontractors to execute and deliver the certification to the State on an annual basis, so long as the Subcontractor has access to State databases containing PII.

9. CONFLICTS OF INTEREST

A. Actual Conflicts of Interest

Contractor shall not engage in any business or activities, or maintain any relationships that conflict in any way with the full performance of the obligations of Contractor under this Contract. Such a conflict of interest would arise when a Contractor's or Subcontractor's employee, officer or agent were to offer or provide any tangible personal benefit to an employee of the State, or any member of his or her immediate family or his or her partner, related to the award of, entry into or management or oversight of this Contract.

B. Apparent Conflicts of Interest

Contractor acknowledges that, with respect to this Contract, even the appearance of a conflict of interest shall be harmful to the State's interests. Absent the State's prior written approval, Contractor shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Contractor's obligations under this Contract.

C. Disclosure to the State

If a conflict or the appearance of a conflict arises, or if Contractor is uncertain whether a conflict or the appearance of a conflict has arisen, Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the actual or apparent conflict constitutes a Breach of Contract.

D. Acknowledgement

Contractor acknowledges that all State employees are subject to the ethical principles described in §24-18-105, C.R.S. Contractor further acknowledges that State employees may be subject to the requirements of §24-18-105, C.R.S. with regard to this Contract.

10. INSURANCE

Contractor shall obtain and maintain, and ensure that each Subcontractor shall obtain and maintain, insurance as specified in this section at all times during the term of this Contract. All insurance policies required by this Contract shall be issued by insurance companies as approved by the State.

A. Workers' Compensation

Workers' compensation insurance as required by state statute, and employers' liability insurance covering all Contractor or Subcontractor employees acting within the course and scope of their employment.

B. General Liability

Commercial general liability insurance covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows:

i. $1,000,000 each occurrence;

ii. $1,000,000 general aggregate;

iii. $1,000,000 products and completed operations aggregate; and

iv. $50,000 any one fire.

C. Automobile Liability

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

D. Protected Information

Liability insurance covering all civil, regulatory, and statutory damages, contractual damages, data breach management exposure, and all loss income or extra expense as a result of actual or alleged breach, violation or infringement of a right to privacy, consumer data protection law, confidentiality or other legal protection for personal information as well as State Confidential Information with minimum limits as follows:

i. $1,000,000 each occurrence; and

ii. $2,000,000 general aggregate.

E. Professional Liability Insurance

Professional liability insurance covering any damages caused by an error, omission or any negligent act with minimum limits as follows:

i. $1,000,000 each occurrence; and

ii. $1,000,000 general aggregate.

F. Crime Insurance

Crime insurance including employee dishonesty coverage with minimum limits as follows:

i. $1,000,000 each occurrence; and

ii. $1,000,000 general aggregate.

G. Additional Insured

The State shall be named as additional insured on all commercial general liability policies (leases and construction contracts require additional insured coverage for completed operations) required of Contractor and Subcontractors.

H. Primacy of Coverage

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

I. Cancellation

The above insurance policies shall include provisions preventing cancellation or non-renewal, except for cancellation based on non-payment of premiums, without at least 30 days prior notice to Contractor and Contractor shall forward such notice to the State in accordance with **§14** within seven days of Contractor's receipt of such notice.

J. Subrogation Waiver

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

K. Public Entities

If Contractor is a "public entity" within the meaning of the Colorado Governmental Immunity Act, §§24-10-101, *et seq.*, C.R.S. (the "GIA"), Contractor shall maintain, in lieu of the liability insurance requirements stated above, at all times during the term of this Contract such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the GIA. If a Subcontractor is a public entity within the meaning of the GIA, Contractor shall ensure that the Subcontractor maintains at all times during the terms of this Contract, in lieu of the liability insurance requirements stated above, such liability insurance, by commercial policy or self-insurance, as is necessary to meet the Subcontractor's obligations under the GIA.

L. Certificates

Contractor shall provide to the State certificates evidencing Contractor's insurance coverage required in this Contract within seven Business Days following the Effective Date. Contractor shall provide to the State certificates evidencing Subcontractor insurance coverage required under this Contract within seven Business Days following the Effective Date, except that, if Contractor's subcontract is not in effect as of the Effective Date, Contractor shall provide to the State certificates showing Subcontractor insurance coverage required under this Contract within seven Business Days following Contractor's execution of the subcontract. No later than 15 days before the expiration date of Contractor's or any Subcontractor's coverage, Contractor shall deliver to the State certificates of insurance evidencing renewals of coverage. At any other time during the term of this Contract, upon request by the State, Contractor shall, within seven Business Days following the request by the State, supply to the State evidence satisfactory to the State of compliance with the provisions of this section. Contractor shall provide all certificates electronically to the Department's designated insurance certificate submission site, unless the Department has specifically directed otherwise.

11. BREACH OF CONTRACT

In the event of a Breach of Contract, the aggrieved Party shall give written notice of breach to the other Party. If the notified Party does not cure the Breach of Contract, at its sole expense, within 30 days after the delivery of written notice, the Party may exercise any of the remedies as described in **§12** for that Party. Notwithstanding any provision of this Contract to the contrary, the State, in its discretion, need not provide notice or a cure period and may immediately terminate this Contract in whole or in part or institute any other remedy in this Contract in order

to protect the public interest of the State; or if Contractor is debarred or suspended under §24-109-105, C.R.S., the State, in its discretion, need not provide notice or cure period and may terminate this Contract in whole or in part or institute any other remedy in this Contract as of the date that the debarment or suspension takes effect.

12. REMEDIES

A. State's Remedies

If Contractor is in breach under any provision of this Contract and fails to cure such breach, the State, following the notice and cure period set forth in **§11,** shall have all of the remedies listed in this section in addition to all other remedies set forth in this Contract or at law. The State may exercise any or all of the remedies available to it, in its discretion, concurrently or consecutively.

i. Termination for Breach of Contract

In the event of Contractor's uncured breach, the State may terminate this entire Contract or any part of this Contract. Contractor shall continue performance of this Contract to the extent not terminated, if any.

a. Obligations and Rights

To the extent specified in any termination notice, Contractor shall not incur further obligations or render further performance past the effective date of such notice, and shall terminate outstanding orders and subcontracts with third parties. However, Contractor shall complete and deliver to the State all Work not cancelled by the termination notice, and may incur obligations as necessary to do so within this Contract's terms. At the request of the State, Contractor shall assign to the State all of Contractor's rights, title, and interest in and to such terminated orders or subcontracts. Upon termination, Contractor shall take timely, reasonable and necessary action to protect and preserve property in the possession of Contractor but in which the State has an interest. At the State's request, Contractor shall return materials owned by the State in Contractor's possession at the time of any termination. Contractor shall deliver all completed Work Product and all Work Product that was in the process of completion to the State at the State's request.

b. Payments

Notwithstanding anything to the contrary, the State shall only pay Contractor for accepted Work received as of the date of termination. If, after termination by the State, the State agrees that Contractor was not in breach or that Contractor's action or inaction was excusable, such termination shall be treated as a termination in the public interest, and the rights and obligations of the Parties shall be as if this Contract had been terminated in the public interest under **§2.E**.

c. Damages and Withholding

Notwithstanding any other remedial action by the State, Contractor shall remain liable to the State for any damages sustained by the State in connection with any breach by Contractor, and the State may withhold payment to Contractor for the purpose of mitigating the State's damages until such time as the exact amount of

damages due to the State from Contractor is determined. The State may withhold any amount that may be due Contractor as the State deems necessary to protect the State against loss including, without limitation, loss as a result of outstanding liens and excess costs incurred by the State in procuring from third parties replacement Work as cover.

ii. Remedies Not Involving Termination

The State, in its discretion, may exercise one or more of the following additional remedies:

a. Suspend Performance

Suspend Contractor's performance with respect to all or any portion of the Work pending corrective action as specified by the State without entitling Contractor to an adjustment in price or cost or an adjustment in the performance schedule. Contractor shall promptly cease performing Work and incurring costs in accordance with the State's directive, and the State shall not be liable for costs incurred by Contractor after the suspension of performance.

b. Withhold Payment

Withhold payment to Contractor until Contractor corrects its Work.

c. Deny Payment

Deny payment for Work not performed, or that due to Contractor's actions or inactions, cannot be performed or if they were performed are reasonably of no value to the State; provided, that any denial of payment shall be equal to the value of the obligations not performed.

d. Removal

Demand immediate removal of any of Contractor's employees, agents, or Subcontractors from the Work whom the State deems incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable or whose continued relation to this Contract is deemed by the State to be contrary to the public interest or the State's best interest.

e. Intellectual Property

If any Work infringes, or if the State in its sole discretion determines that any Work is likely to infringe, a patent, copyright, trademark, trade secret or other intellectual property right, Contractor shall, as approved by the State **(i)** secure that right to use such Work for the State and Contractor; **(ii)** replace the Work with noninfringing Work or modify the Work so that it becomes noninfringing; or, **(iii)** remove any infringing Work and refund the amount paid for such Work to the State.

B. Contractor's Remedies

If the State is in breach of any provision of this Contract and does not cure such breach, Contractor, following the notice and cure period in **§11** and the dispute resolution process in **§13** shall have all remedies available at law and equity.

13. DISPUTE RESOLUTION

A. Initial Resolution

Except as herein specifically provided otherwise, disputes concerning the performance of this Contract which cannot be resolved by the designated Contract representatives shall be referred in writing to a senior departmental management staff member designated by the State and a senior manager designated by Contractor for resolution.

B. Resolution of Controversies

If the initial resolution described in **§13.A** fails to resolve the dispute within 10 Business Days, Contractor shall submit any alleged breach of this Contract by the State to the Procurement Official of the State Agency named on the Cover Page of this Contract as described in §24-102-202(3), C.R.S. for resolution in accordance with the provisions of §24-106-109, C.R.S., and §§24-109-101.1 through 24-109-505, C.R.S., (the "Resolution Statutes"), except that if Contractor wishes to challenge any decision rendered by the Procurement Official, Contractor's challenge shall be an appeal to the Executive Director of the Department of Personnel and Administration, or their delegate, under the Resolution Statutes before Contractor pursues any further action as permitted by such statutes. Except as otherwise stated in this Section, all requirements of the Resolution Statutes shall apply including, without limitation, time limitations.

14. NOTICES AND REPRESENTATIVES

Each individual identified as a Principal Representative on the Cover Page for this Contract shall be the principal representative of the designating Party. All notices required or permitted to be given under this Contract shall be in writing, and shall be delivered **(A)** by hand with receipt required, **(B)** by certified or registered mail to such Party's principal representative at the address set forth on the Cover Page for this Contract, or **(C)** as an email with read receipt requested to the principal representative at the email address, if any, set forth on the Cover Page for this Contract. If a Party delivers a notice to another through email and the email is undeliverable, then, unless the Party has been provided with an alternate email contact, the Party delivering the notice shall deliver the notice by hand with receipt required or by certified or registered mail to such Party's principal representative at the address set forth on the Cover Page for this Contract. Either Party may change its principal representative or principal representative contact information, or may designate specific other individuals to receive certain types of notices in addition to or in lieu of a principal representative by notice submitted in accordance with this section without a formal amendment to this Contract. Unless otherwise provided in this Contract, notices shall be effective upon delivery of the written notice.

15. RIGHTS IN WORK PRODUCT AND OTHER INFORMATION

A. Work Product

i. Copyrights

To the extent that the Work Product (or any portion of the Work Product) would not be considered works made for hire under applicable law, Contractor hereby assigns to the State, the entire right, title, and interest in and to copyrights in all Work Product and all works based upon, derived from, or incorporating the Work Product; all copyright applications, registrations, extensions, or renewals relating to all Work Product and all works based upon, derived from, or incorporating the Work Product;

and all moral rights or similar rights with respect to the Work Product throughout the world. To the extent that Contractor cannot make any of the assignments required by this section, Contractor hereby grants to the State a perpetual, irrevocable, royalty-free license to use, modify, copy, publish, display, perform, transfer, distribute, sell, and create derivative works of the Work Product and all works based upon, derived from, or incorporating the Work Product by all means and methods and in any format now known or invented in the future. The State may assign and license its rights under this license.

ii. Patents

In addition, Contractor grants to the State (and to recipients of Work Product distributed by or on behalf of the State) a perpetual, worldwide, no-charge, royalty-free, irrevocable patent license to make, have made, use, distribute, sell, offer for sale, import, transfer, and otherwise utilize, operate, modify and propagate the contents of the Work Product. Such license applies only to those patent claims licensable by Contractor that are necessarily infringed by the Work Product alone, or by the combination of the Work Product with anything else used by the State.

iii. Assignments and Assistance

Whether or not Contractor is under contract with the State at the time, Contractor shall execute applications, assignments, and other documents, and shall render all other reasonable assistance requested by the State, to enable the State to secure patents, copyrights, licenses and other intellectual property rights related to the Work Product. To the extent that Work Product would fall under the definition of "works made for hire" under 17 U.S.C.S. §101, the Parties intend the Work Product to be a work made for hire. Contractor assigns to the State and its successors and assigns, the entire right, title, and interest in and to all causes of action, either in law or in equity, for past, present, or future infringement of intellectual property rights related to the Work Product and all works based on, derived from, or incorporating the Work Product.

B. Exclusive Property of the State

Except to the extent specifically provided elsewhere in this Contract, all State Records, 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 information provided by or on behalf of the State to Contractor are the exclusive property of the State (collectively, "State Materials"). Contractor shall not use, willingly allow, cause or permit Work Product or State Materials to be used for any purpose other than the performance of Contractor's obligations in this Contract without the prior written consent of the State. Upon termination of this Contract for any reason, Contractor shall provide all Work Product and State Materials to the State in a form and manner as directed by the State.

C. Exclusive Property of Contractor

Contractor retains the exclusive rights, title, and ownership to any and all pre-existing materials owned or licensed to Contractor including, but not limited to, all pre-existing software, licensed products, associated source code, machine code, text images, audio

and/or video, and third-party materials, delivered by Contractor under the Contract, whether incorporated in a Deliverable or necessary to use a Deliverable (collectively, "Contractor Property"). Contractor Property shall be licensed to the State as set forth in this Contract or a State approved license agreement: **(i)** entered into as exhibits to this Contract; **(ii)** obtained by the State from the applicable third-party vendor; or **(iii)** in the case of open source software, the license terms set forth in the applicable open source license agreement.

16. GENERAL PROVISIONS

A. Assignment

Contractor's rights and obligations under this Contract are personal and may not be transferred or assigned without the prior, written consent of the State. Any attempt at assignment or transfer without such consent shall be void. Any assignment or transfer of Contractor's rights and obligations approved by the State shall be subject to the provisions of this Contract.

B. Subcontracts

Contractor shall not enter into any subcontract in connection with its obligations under this Contract without the prior, written approval of the State. Contractor shall submit to the State a copy of each such subcontract upon request by the State. All subcontracts entered into by Contractor in connection with this Contract shall comply with all applicable federal and state laws and regulations, shall provide that they are governed by the laws of the State of Colorado, and shall be subject to all provisions of this Contract.

C. Binding Effect

Except as otherwise provided in **§16.A**, all provisions of this Contract, including the benefits and burdens, shall extend to and be binding upon the Parties' respective successors and assigns.

D. Authority

Each Party represents and warrants to the other that the execution and delivery of this Contract and the performance of such Party's obligations have been duly authorized.

E. Captions and References

The captions and headings in this Contract are for convenience of reference only, and shall not be used to interpret, define, or limit its provisions. All references in this Contract to sections (whether spelled out or using the § symbol), subsections, exhibits or other attachments, are references to sections, subsections, exhibits or other attachments contained herein or incorporated as a part hereof, unless otherwise noted.

F. Counterparts

This Contract may be executed in multiple, identical, original counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

G. Entire Understanding

This Contract represents the complete integration of all understandings between the Parties related to the Work, and all prior representations and understandings related to the Work, oral or written, are merged into this Contract. Prior or contemporaneous additions,

deletions, or other changes to this Contract shall not have any force or effect whatsoever, unless embodied herein.

H. Digital Signatures

If any signatory signs this Contract using a digital signature in accordance with the Colorado State Controller Contract, Grant and Purchase Order Policies regarding the use of digital signatures issued under the State Fiscal Rules, then any agreement or consent to use digital signatures within the electronic system through which that signatory signed shall be incorporated into this Contract by reference.

I. Modification

Except as otherwise provided in this Contract, any modification to this Contract shall only be effective if agreed to in a formal amendment to this Contract, properly executed and approved in accordance with applicable Colorado State law and State Fiscal Rules. Modifications permitted under this Contract, other than contract amendments, shall conform to the policies issued by the Colorado State Controller.

J. Statutes, Regulations, Fiscal Rules, and Other Authority

Any reference in this Contract to a statute, regulation, State Fiscal Rule, fiscal policy or other authority shall be interpreted to refer to such authority then current, as may have been changed or amended since the Effective Date of this Contract.

K. External Terms and Conditions

Notwithstanding anything to the contrary herein, the State shall not be subject to any provision included in any terms, conditions, or agreements appearing on Contractor's or a Subcontractor's website or any provision incorporated into any click-through or online agreements related to the Work unless that provision is specifically referenced in this Contract.

L. Severability

The invalidity or unenforceability of any provision of this Contract shall not affect the validity or enforceability of any other provision of this Contract, which shall remain in full force and effect, provided that the Parties can continue to perform their obligations under this Contract in accordance with the intent of this Contract.

M. Survival of Certain Contract Terms

Any provision of this Contract that imposes an obligation on a Party after termination or expiration of this Contract shall survive the termination or expiration of this Contract and shall be enforceable by the other Party.

N. Taxes

The State is exempt from federal excise taxes under I.R.C. Chapter 32 (26 U.S.C., Subtitle D, Ch. 32) (Federal Excise Tax Exemption Certificate of Registry No. 84-730123K) and from State and local government sales and use taxes under §§39-26-704(1), *et seq.*, C.R.S. (Colorado Sales Tax Exemption Identification Number 98-02565). The State shall not be liable for the payment of any excise, sales, or use taxes, regardless of whether any political subdivision of the state imposes such taxes on Contractor. Contractor shall be solely

responsible for any exemptions from the collection of excise, sales or use taxes that Contractor may wish to have in place in connection with this Contract.

O. Third Party Beneficiaries

Except for the Parties' respective successors and assigns described in **§ 16.A,** this Contract does not and is not intended to confer any rights or remedies upon any person or entity other than the Parties. Enforcement of this Contract and all rights and obligations hereunder are reserved solely to the Parties. Any services or benefits which third parties receive as a result of this Contract are incidental to this Contract, and do not create any rights for such third parties.

P. Waiver

A Party's failure or delay in exercising any right, power, or privilege under this Contract, whether explicit or by lack of enforcement, shall not operate as a waiver, nor shall any single or partial exercise of any right, power, or privilege preclude any other or further exercise of such right, power, or privilege.

Q. CORA Disclosure

To the extent not prohibited by federal law, this Contract and the performance measures and standards required under §24-106-107, C.R.S., if any, are subject to public release through the CORA.

R. Standard and Manner of Performance

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

S. Licenses, Permits, and Other Authorizations

Contractor shall secure, prior to the Effective Date, and maintain at all times during the term of this Contract, at its sole expense, all licenses, certifications, permits, and other authorizations required to perform its obligations under this Contract, and shall ensure that all employees, agents and Subcontractors secure and maintain at all times during the term of their employment, agency or subcontract, all licenses, certifications, permits and other authorizations required to perform their obligations in relation to this Contract.

T. Indemnification

i. General Indemnification

Contractor shall indemnify, save, and hold harmless the State, its employees, agents and assignees (the "Indemnified Parties"), against any and all costs, expenses, claims, damages, liabilities, court awards and other amounts (including attorneys' fees and related costs) incurred by any of the Indemnified Parties in relation to any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees in connection with this Contract.

ii. Confidential Information Indemnification

Disclosure or use of State Confidential Information by Contractor in violation of **§8** may be cause for legal action by third parties against Contractor, the State, or their respective agents. Contractor shall indemnify, save, and hold harmless the Indemnified Parties, against any and all claims, damages, liabilities, losses, costs,

expenses (including attorneys' fees and costs) incurred by the State in relation to any act or omission by Contractor, or its employees, agents, assigns, or Subcontractors in violation of **§8**.

iii. Intellectual Property Indemnification

Contractor shall indemnify, save, and hold harmless the Indemnified Parties, against any and all costs, expenses, claims, damages, liabilities, and other amounts (including attorneys' fees and costs) incurred by the Indemnified Parties in relation to any claim that any Deliverable, Good or Service, software, or Work Product provided by Contractor under this Contract (collectively, "IP Deliverables"), or the use thereof, infringes a patent, copyright, trademark, trade secret, or any other intellectual property right. Contractor's obligations hereunder shall not extend to the combination of any IP Deliverables provided by Contractor with any other product, system, or method, unless the other product, system, or method is **(a)** provided by Contractor or Contractor's subsidiaries or affiliates; **(b)** specified by Contractor to work with the IP Deliverables; **(c)** reasonably required in order to use the IP Deliverables in its intended manner and the infringement could not have been avoided by substituting another reasonably available product, system, or method capable of performing the same function; or **(d)** is reasonably expected to be used in combination with the IP Deliverables.

iv. Accessibility Indemnification

Contractor shall indemnify, save, and hold harmless the state, its employees, agents and assignees (collectively, the "Indemnified Parties"), against any and all costs, expenses, claims, damages, liabilities, court awards and other amounts (including attorneys' fees and related costs) incurred by any of the Indemnified Parties in relation to Contractor's failure to comply with §§24-85-101, et seq., C.R.S., or the Accessibility Standards for Individuals with a Disability as established by the Office of Information Technology pursuant to Section §24-85-103 (2.5), C.R.S.

U. Accessibility

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

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

V. Additional ProvisionsContractor shall comply with all requirements shown in Exhibit A and Exhibit G.

17. COLORADO SPECIAL PROVISIONS (COLORADO FISCAL RULE 3-3)

These Special Provisions apply to all contracts except where noted in italics.

A. STATUTORY APPROVAL. §24-30-202(1), C.R.S.

This Contract shall not be valid until it has been approved by the Colorado State Controller or designee. If this Contract is for a Major Information Technology Project, as defined in §24-37.5-102(2.6), C.R.S., then this Contract shall not be valid until it has been approved by the State's Chief Information Officer or designee.

B. FUND AVAILABILITY. §24-30-202(5.5), C.R.S.

Financial obligations of the State payable after the current State Fiscal Year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

C. GOVERNMENTAL IMMUNITY.

Liability for claims for injuries to persons or property arising from the negligence of the State, its departments, boards, commissions committees, bureaus, offices, employees and officials shall be controlled and limited by the provisions of the Colorado Governmental Immunity Act, §24-10-101, et seq., C.R.S.; the Federal Tort Claims Act, 28 U.S.C. Pt. VI, Ch. 171 and 28 U.S.C. 1346(b), and the State's risk management statutes, §§24-30-1501, *et seq*. C.R.S. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, contained in these statutes.

D. INDEPENDENT CONTRACTOR.

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

E. COMPLIANCE WITH LAW.

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

F. CHOICE OF LAW, JURISDICTION, AND VENUE.

Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this Contract. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. All suits or actions related to this Contract shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver.

G. PROHIBITED TERMS.

Any term included in this Contract that requires the State to indemnify or hold Contractor harmless; requires the State to agree to binding arbitration; limits Contractor's liability for damages resulting from death, bodily injury, or damage to tangible property; or that conflicts with this provision in any way shall be void ab initio. Nothing in this Contract shall be construed as a waiver of any provision of §24-106-109, C.R.S.

H. SOFTWARE PIRACY PROHIBITION.

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

I. EMPLOYEE FINANCIAL INTEREST/CONFLICT OF INTEREST. §§24-18-201 and 24-50-507, C.R.S.

The signatories aver that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this Contract. Contractor has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Contractor's services and Contractor shall not employ any person having such known interests.

J. VENDOR OFFSET AND ERRONEOUS PAYMENTS. §§24-30-202(1) and 24-30-202.4, C.R.S.

[*Not applicable to intergovernmental agreements*] Subject to §24-30-202.4(3.5), C.R.S., the State Controller may withhold payment under the State's vendor offset intercept system for debts owed to State agencies for: **(i)** unpaid child support debts or child support arrearages; **(ii)** unpaid balances of tax, accrued interest, or other charges specified in §§39-21-101, *et seq.*, C.R.S.; **(iii)** unpaid loans due to the Student Loan Division of the Department of Higher Education; **(iv)** amounts required to be paid to the Unemployment Compensation Fund; and **(v)** other unpaid debts owing to the State as a result of final agency determination or judicial action. The State may also recover, at the State's discretion, payments made to Contractor in error for any reason, including, but not limited to, overpayments or improper payments, and unexpended or excess funds received by Contractor by deduction from subsequent payments under this Contract, deduction from

any payment due under any other contracts, grants or agreements between the State and Contractor, or by any other appropriate method for collecting debts owed to the State.

EXHIBIT A, HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Agreement") between the State and Contractor is agreed to in connection with, and as an exhibit to, the Contract. For purposes of this Agreement, the State is referred to as "Covered Entity" and Contractor is referred to as "Business Associate". Unless the context clearly requires a distinction between the Contract and this Agreement, all references to "Contract" shall include this Agreement.

1. Purpose

Covered Entity wishes to disclose information to Business Associate, which may include Protected Health Information ("PHI"). The Parties intend to protect the privacy and security of the disclosed PHI in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191 (1996) as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") enacted under the American Recovery and Reinvestment Act of 2009 ("ARRA") Pub. L. No. 111–5 (2009), implementing regulations promulgated by the U.S. Department of Health and Human Services at 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Rules") and other applicable laws, as amended. Prior to the disclosure of PHI, Covered Entity is required to enter into an agreement with Business Associate containing specific requirements 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 all other applicable laws and regulations, all as may be amended.

2. Definitions

The following terms used in this Agreement shall have the same meanings as in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

The following terms used in this Agreement shall have the meanings set forth below:

A. Business Associate. "Business Associate" shall have the same meaning as the term "business associate" at 45 C.F.R. 160.103, and shall refer to Contractor.

B. Covered Entity. "Covered Entity" shall have the same meaning as the term "covered entity" at 45 C.F.R. 160.103, and shall refer to the State.

C. Information Technology and Information Security. "Information Technology" and "Information Security" shall have the same meanings as the terms "information technology" and "information security", respectively, in §24-37.5-102, C.R.S.

Capitalized terms used herein and not otherwise defined herein or in the HIPAA Rules shall have the meanings ascribed to them in the Contract.

3. Obligations and Activities of Business Associate

A. Permitted Uses and Disclosures.

i. Business Associate shall use and disclose PHI only to accomplish Business Associate's obligations under the Contract.

ii. To the extent Business Associate carries out one or more of Covered Entity's obligations under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply

with any and all requirements of Subpart E that apply to Covered Entity in the performance of such obligation.

iii. Business Associate may disclose PHI to carry out the legal responsibilities of Business Associate, provided, that the disclosure is Required by Law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that:

a. the information will remain confidential and will be used or disclosed only as Required by Law or for the purpose for which Business Associate originally disclosed the information to that person, and;

b. the person notifies Business Associate of any Breach involving PHI of which it is aware.

iv. Business Associate may provide Data Aggregation services relating to the Health Care Operations of Covered Entity. Business Associate may de-identify any or all PHI created or received by Business Associate under this Agreement, provided the de-identification conforms to the requirements of the HIPAA Rules.

B. Minimum Necessary.

Business Associate, its Subcontractors and agents, shall access, use, and disclose only the minimum amount of PHI necessary to accomplish the objectives of the Contract, in accordance with the Minimum Necessary Requirements of the HIPAA Rules including, but not limited to, 45 C.F.R. 164.502(b) and 164.514(d).

C. Impermissible Uses and Disclosures.

i. Business Associate shall not disclose the PHI of Covered Entity to another covered entity without the written authorization of Covered Entity.

ii. Business Associate shall not share, use, disclose or make available any Covered Entity PHI in any form via any medium with or to any person or entity beyond the boundaries or jurisdiction of the United States without express written authorization from Covered Entity.

D. Business Associate's Subcontractors.

i. Business Associate shall, in accordance with 45 C.F.R. 164.502(e)(1)(ii) and 164.308(b)(2), ensure that any Subcontractors who create, receive, maintain, or transmit PHI on behalf of Business Associate agree in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to safeguarding PHI.

ii. Business Associate shall provide to Covered Entity, on Covered Entity's request, a list of Subcontractors who have entered into any such agreement with Business Associate.

iii. Business Associate shall provide to Covered Entity, on Covered Entity's request, copies of any such agreements Business Associate has entered into with Subcontractors.

E. Access to System.

If Business Associate needs access to a Covered Entity Information Technology system to comply with its obligations under the Contract or this Agreement, Business Associate shall

request, review, and comply with any and all policies applicable to Covered Entity regarding such system including, but not limited to, any policies promulgated by the Office of Information Technology and available at http://oit.state.co.us/about/policies.

F. Access to PHI.

Business Associate shall, within ten days of receiving a written request from Covered Entity, make available PHI in a Designated Record Set to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 C.F.R. 164.524.

G. Amendment of PHI.

i. Business Associate shall within ten days of receiving a written request from Covered Entity make any amendment to PHI in a Designated Record Set as directed by or agreed to by Covered Entity pursuant to 45 C.F.R. 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. 164.526.

ii. Business Associate shall promptly forward to Covered Entity any request for amendment of PHI that Business Associate receives directly from an Individual.

H. Accounting Rights.

Business Associate shall, within ten days of receiving a written request from Covered Entity, maintain and make available to Covered Entity the information necessary for Covered Entity to satisfy its obligations to provide an accounting of Disclosure under 45 C.F.R. 164.528.

I. Restrictions and Confidential Communications.

i. Business Associate shall restrict the Use or Disclosure of an Individual's PHI within ten days of notice from Covered Entity of:

a. a restriction on Use or Disclosure of PHI pursuant to 45 C.F.R. 164.522; or

b. a request for confidential communication of PHI pursuant to 45 C.F.R. 164.522.

ii. Business Associate shall not respond directly to an Individual's requests to restrict the Use or Disclosure of PHI or to send all communication of PHI to an alternate address.

iii. Business Associate shall refer such requests to Covered Entity so that Covered Entity can coordinate and prepare a timely response to the requesting Individual and provide direction to Business Associate.

J. Governmental Access to Records.

Business Associate shall make its facilities, internal practices, books, records, and other sources of information, including PHI, available to the Secretary for purposes of determining compliance with the HIPAA Rules in accordance with 45 C.F.R. 160.310.

K. Audit, Inspection and Enforcement.

i. Business Associate shall obtain and update at least annually a written assessment performed by an independent third party reasonably acceptable to Covered Entity, which evaluates the Information Security of the applications, infrastructure, and processes that interact with the Covered Entity data Business Associate receives, manipulates, stores and distributes. Upon request by Covered Entity, Business Associate shall provide to Covered Entity the executive summary of the assessment.

ii. Business Associate, upon the request of Covered Entity, shall fully cooperate with Covered Entity's efforts to audit Business Associate's compliance with applicable HIPAA Rules. If, through audit or inspection, Covered Entity determines that Business Associate's conduct would result in violation of the HIPAA Rules or is in violation of the Contract or this Agreement, Business Associate shall promptly remedy any such violation and shall certify completion of its remedy in writing to Covered Entity.

L. Appropriate Safeguards.

i. Business Associate shall use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to prevent use or disclosure of PHI other than as provided in this Agreement.

ii. Business Associate shall safeguard the PHI from tampering and unauthorized disclosures.

iii. Business Associate shall maintain the confidentiality of passwords and other data required for accessing this information.

iv. Business Associate shall extend protection beyond the initial information obtained from Covered Entity to any databases or collections of PHI containing information derived from the PHI. The provisions of this section shall be in force unless PHI is de-identified in conformance to the requirements of the HIPAA Rules.

M. Safeguard During Transmission.

i. Business Associate shall use reasonable and appropriate safeguards including, without limitation, Information Security measures to ensure that all transmissions of PHI are authorized and to prevent use or disclosure of PHI other than as provided for by this Agreement.

ii. Business Associate shall not transmit PHI over the internet or any other insecure or open communication channel unless the PHI is encrypted or otherwise safeguarded with a FIPS-compliant encryption algorithm.

N. Reporting of Improper Use or Disclosure and Notification of Breach.

i. Business Associate shall, as soon as reasonably possible, but immediately after discovery of a Breach, notify Covered Entity of any use or disclosure of PHI not provided for by this Agreement, including a Breach of Unsecured Protected Health Information as such notice is required by 45 C.F.R. 164.410 or a breach for which notice is required under §24-73-103, C.R.S.

ii. Such notice shall include the identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach.

iii. Business Associate shall, as soon as reasonably possible, but immediately after discovery of any Security Incident that does not constitute a Breach, notify Covered Entity of such incident.

iv. Business Associate shall have the burden of demonstrating that all notifications were made as required, including evidence demonstrating the necessity of any delay.

O. Business Associate's Insurance and Notification Costs.

i. Business Associate shall bear all costs of a Breach response including, without limitation, notifications, and shall maintain insurance to cover:

a. loss of PHI data;

b. Breach notification requirements specified in HIPAA Rules and in §24-73-103, C.R.S.; and

c. claims based upon alleged violations of privacy rights through improper use or disclosure of PHI.

ii. All such policies shall meet or exceed the minimum insurance requirements of the Contract or otherwise as may be approved by Covered Entity (e.g., occurrence basis, combined single dollar limits, annual aggregate dollar limits, additional insured status, and notice of cancellation).

iii. Business Associate shall provide Covered Entity a point of contact who possesses relevant Information Security knowledge and is accessible 24 hours per day, 7 days per week to assist with incident handling.

iv. Business Associate, to the extent practicable, shall mitigate any harmful effect known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of this Agreement.

P. Subcontractors and Breaches.

i. Business Associate shall enter into a written agreement with each of its Subcontractors and agents, who create, receive, maintain, or transmit PHI on behalf of Business Associate. The agreements shall require such Subcontractors and agents to report to Business Associate any use or disclosure of PHI not provided for by this Agreement, including Security Incidents and Breaches of Unsecured Protected Health Information, on the first day such Subcontractor or agent knows or should have known of the Breach as required by 45 C.F.R. 164.410.

ii. Business Associate shall notify Covered Entity of any such report and shall provide copies of any such agreements to Covered Entity on request.

Q. Data Ownership.

i. Business Associate acknowledges that Business Associate has no ownership rights with respect to the PHI.

ii. Upon request by Covered Entity, Business Associate immediately shall provide Covered Entity with any keys to decrypt information that the Business Association has encrypted and maintains in encrypted form, or shall provide such information in unencrypted usable form.

R. Retention of PHI.

Except upon termination of this Agreement as provided in Section 5 below, Business Associate and its Subcontractors or agents shall retain all PHI throughout the term of this Agreement, and shall continue to maintain the accounting of disclosures required under Section3. H above, for a period of six years.

4. Obligations of Covered Entity

A. Safeguards During Transmission.

Covered Entity shall be responsible for using appropriate safeguards including encryption of PHI, to maintain and ensure the confidentiality, integrity, and security of PHI transmitted pursuant to this Agreement, in accordance with the standards and requirements of the HIPAA Rules.

B. Notice of Changes.

i. Covered Entity maintains a copy of its Notice of Privacy Practices on its website. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission to use or disclose PHI, to the extent that it may affect Business Associate's permitted or required uses or disclosures.

ii. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. 164.522, to the extent that it may affect Business Associate's permitted use or disclosure of PHI.

5. Termination

A. Breach.

i. In addition to any Contract provision regarding remedies for breach, Covered Entity shall have the right, in the event of a breach by Business Associate of any provision of this Agreement, to terminate immediately the Contract, or this Agreement, or both.

ii. Subject to any directions from Covered Entity, upon termination of the Contract, this Agreement, or both, Business Associate shall take timely, reasonable, and necessary action to protect and preserve property in the possession of Business Associate in which Covered Entity has an interest.

B. Effect of Termination.

i. Upon termination of this Agreement for any reason, Business Associate, at the option of Covered Entity, shall return or destroy all PHI that Business Associate, its agents, or its Subcontractors maintain in any form, and shall not retain any copies of such PHI.

ii. If Covered Entity directs Business Associate to destroy the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

iii. If Business Associate believes that returning or destroying the PHI is not feasible, Business Associate shall promptly provide Covered Entity with notice of the conditions making return or destruction infeasible. Business Associate shall continue to extend the protections of Section 3 of this Agreement to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

6. Injunctive Relief

Covered Entity and Business Associate agree that irreparable damage would occur in the event Business Associate or any of its Subcontractors or agents use or disclosure of PHI in violation of this Agreement, the HIPAA Rules or any applicable law. Covered Entity and Business Associate further agree that money damages would not provide an adequate remedy for such Breach.

Accordingly, Covered Entity and Business Associate agree that Covered Entity shall be entitled to injunctive relief, specific performance, and other equitable relief to prevent or restrain any Breach or threatened Breach of and to enforce specifically the terms and provisions of this Agreement.

7. Limitation of Liability

Any provision in the Contract limiting Contractor's liability shall not apply to Business Associate's liability under this Agreement, which shall not be limited.

8. Disclaimer

Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement or the HIPAA Rules will be adequate or satisfactory for Business Associate's own purposes. Business Associate is solely responsible for all decisions made and actions taken by Business Associate regarding the safeguarding of PHI.

9. Certification

Covered Entity has a legal obligation under HIPAA Rules to certify as to Business Associate's Information Security practices. Covered Entity or its authorized agent or contractor shall have the right to examine Business Associate's facilities, systems, procedures, and records, at Covered Entity's expense, if Covered Entity determines that examination is necessary to certify that Business Associate's Information Security safeguards comply with the HIPAA Rules or this Agreement.

10. Amendment

A. Amendment to Comply with Law.

The Parties acknowledge that state and federal laws and regulations relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide procedures to ensure compliance with such developments.

i. In the event of any change to state or federal laws and regulations relating to data security and privacy affecting this Agreement, the Parties shall take such action as is necessary to implement the changes to the standards and requirements of HIPAA, the HIPAA Rules and other applicable rules relating to the confidentiality, integrity, availability and security of PHI with respect to this Agreement.

ii. Business Associate shall provide to Covered Entity written assurance satisfactory to Covered Entity that Business Associate shall adequately safeguard all PHI, and obtain written assurance satisfactory to Covered Entity from Business Associate's Subcontractors and agents that they shall adequately safeguard all PHI.

iii. Upon the request of either Party, the other Party promptly shall negotiate in good faith the terms of an amendment to the Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Rules, or other applicable rules.

iv. Covered Entity may terminate this Agreement upon 30 days' prior written notice in the event that:

a. Business Associate does not promptly enter into negotiations to amend the Contract and this Agreement when requested by Covered Entity pursuant to this Section; or

b. Business Associate does not enter into an amendment to the Contract and this Agreement, which provides assurances regarding the safeguarding of PHI sufficient, in Covered Entity's sole discretion, to satisfy the standards and requirements of the HIPAA, the HIPAA Rules and applicable law.

B. Amendment of Appendix.

The Appendix to this Agreement may be modified or amended by the mutual written agreement of the Parties, without amendment of this Agreement. Any modified or amended Appendix agreed to in writing by the Parties shall supersede and replace any prior version of the Appendix.

11. Assistance in Litigation or Administrative Proceedings

Covered Entity shall provide written notice to Business Associate if litigation or administrative proceeding is commenced against Covered Entity, its directors, officers, or employees, based on a claimed violation by Business Associate of HIPAA, the HIPAA Rules or other laws relating to security and privacy or PHI. Upon receipt of such notice and to the extent requested by Covered Entity, Business Associate shall, and shall cause its employees, Subcontractors, or agents assisting Business Associate in the performance of its obligations under the Contract to, assist Covered Entity in the defense of such litigation or proceedings. Business Associate shall, and shall cause its employees, Subcontractor's and agents to, provide assistance, to Covered Entity, which may include testifying as a witness at such proceedings. Business Associate or any of its employees, Subcontractors or agents shall not be required to provide such assistance if Business Associate is a named adverse party.

12. Interpretation and Order of Precedence

Any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules. In the event of an inconsistency between the Contract and this Agreement, this Agreement shall control. This Agreement supersedes and replaces any previous, separately executed HIPAA business associate agreement between the Parties.

13. Survival

Provisions of this Agreement requiring continued performance, compliance, or effect after termination shall survive termination of this contract or this agreement and shall be enforceable by Covered Entity.

APPENDIX TO HIPAA BUSINESS ASSOCIATE AGREEMENT

This Appendix ("Appendix") to the HIPAA Business Associate Agreement ("Agreement") is s an appendix to the Contract and the Agreement. For the purposes of this Appendix, defined terms shall have the meanings ascribed to them in the Agreement and the Contract.

Unless the context clearly requires a distinction between the Contract, the Agreement, and this Appendix, all references to "Contract" or "Agreement" shall include this Appendix.

1. Purpose

This Appendix sets forth additional terms to the Agreement. Any sub-section of this Appendix marked as "Reserved" shall be construed as setting forth no additional terms.

2. Additional Terms

A. Additional Permitted Uses.

In addition to those purposes set forth in the Agreement, Business Associate may use PHI for the following additional purposes:

i. Reserved.

B. Additional Permitted Disclosures.

In addition to those purposes set forth in the Agreement, Business Associate may disclose PHI for the following additional purposes:

i. Reserved.

C. Approved Subcontractors.

Covered Entity agrees that the following Subcontractors or agents of Business Associate may receive PHI under the Agreement:

i. Reserved.

D. Definition of Receipt of PHI.

Business Associate's receipt of PHI under this Contract shall be deemed to occur, and Business Associate's obligations under the Agreement shall commence, as follows:

i. Reserved.

E. Additional Restrictions on Business Associate.

Business Associate agrees to comply with the following additional restrictions on Business Associate's use and disclosure of PHI under the Contract:

i. Reserved.

F. Additional Terms.

Business Associate agrees to comply with the following additional terms under the Agreement:

i. Reserved.

EXHIBIT B, STATEMENT OF WORK

1. REGIONAL ACCOUNTABLE ENTITY (RAE)

1.1. Contractor shall be the RAE for the region and counties defined in Exhibit E. As the RAE, Contractor shall be the Primary Care Case Management Entity (PCCM Entity) and the Prepaid Inpatient Health Plan (PIHP) for Members enrolled with Contractor.

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

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

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

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

1.4.1. Health Maintenance Organization (HMO); or

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

1.5. Contractor shall administer the ACC in compliance with the requirements for both a PCCM Entity and a PIHP set forth in 42 CFR § 438.

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

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

1.6.1. Contractor shall, at a minimum, perform all of the following:

1.6.1.1. Select representatives of the Community to join the governing body which is required to have at least one Member representative.

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

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

1.6.1.4. Include individuals with expertise in Behavioral Health to serve as members of the governing body.

1.6.1.5. Exclude from the governing body any Network Providers that have ownership in Contractor's organization.

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

1.6.1.7. Publicly list information on Contractor's website about the governing body, including, but not limited to, the names of the members of the governing body and their affiliations.

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

1.6.2.1. Contractor shall include as conflicts of interest any party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor including, at minimum, all of the following:

1.6.2.1.1. Agents.

1.6.2.1.2. Managing Employees.

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

1.6.2.1.4. Members of the governing body or governing Board.

1.6.2.1.5. Subcontractors.

1.6.2.1.6. Wholly owned subsidiaries or suppliers.

1.6.2.1.7. Parent companies.

1.6.2.1.8. Sister companies.

1.6.2.1.9. Holding companies.

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

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

1.6.2.3. Contractor shall deliver the RAE Governance Plan to the Department on an annual basis for review and approval.

1.6.2.3.1. **DELIVERABLE**: Annual RAE Governance Plan

1.6.2.3.2. **DUE**: 30 days prior to the Operational Start date, then annually starting, June 1, 2026

1.6.2.3.3. Contractor shall submit an updated written RAE Governance Plan to the Department and post it publicly on Contractor's website when a change is made to the Governance Plan, or a change in governance is discovered by Contractor.

1.6.2.3.4. **DELIVERABLE**: Updated RAE Governance Plan

1.6.2.3.5. **DUE**: Within 30 days after the new change in governance is made or discovered

2. MEMBER ENROLLMENT AND ATTRIBUTION

2.1. Contractor shall review and comply with the Member enrollment, attribution, and assignment processes outlined in this section.

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

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

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

2.1.2.2. Qualified Working Disabled Individuals (QWDI).

2.1.2.3. Qualified Individuals 1 (QI 1).

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

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

2.1.2.6. All individuals while determined presumptively eligible for Medicaid.

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

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

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

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

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

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

2.3. The Department will:

2.3.1. Enroll all Members into the ACC on the same day that Medicaid eligibility notification is received in the interChange from the Colorado Benefit Management System (CBMS).

2.3.1.1. Contractor shall manage Member assignments based on the enrollment data provided by the Department and remain in alignment with Department attribution and assignment policies, including retroactive adjustments for up to 90 days.

2.3.2. Assign Members to Contractor according to the following:

2.3.2.1. Members shall be assigned to Contractor based on the location of the PCMP Practice Site to which the Member is attributed.

2.3.2.2. For unattributed Members, the Department shall assign the Member to the RAE corresponding to the Member's address.

2.3.2.3. Members residing in counties covered by a Managed Care Organization (MCO) and meeting all other eligibility requirements shall be enrolled in the MCO per Department processes.

2.3.3. Assign child and youth Members who gain Medicaid eligibility through dependency and neglect actions resulting in out-of-home placement to the RAE where the Member's case originated, in accordance with § 25.5-5-402(6)(b), C.R.S.

2.4. If a Member loses Medicaid eligibility for two months or less, the Department will automatically re-enroll the Member with the same PCMP and RAE as previously assigned.

2.4.1. Contractor shall monitor re-enrollment notices and ensure a seamless continuation of services for re-enrolled Members.

2.5. Contractor shall:

2.5.1. Accept all Members assigned by the Department in the order assigned and without restriction.

2.5.2. Implement and maintain policies that support the State's "Colorado for All" initiative by prohibiting discrimination against Members based on race, color, ethnicity, national origin, ancestry, age, sex, gender, sexual orientation, gender identity or expression, religion, creed, political beliefs, or disability.

2.5.3. Ensure Members are not discriminated against in enrollment, re-enrollment, or access to services based on health status or need for health care services.

2.6. Member Selection of PCMP:

2.6.1. Members may select a different PCMP at any time through the Enrollment Broker.

2.6.1.1. Contractor shall process updates related to Member PCMP selections and adjust services as required.

2.6.2. A Member's selection of a different PCMP may result in reassignment to a different RAE, the reassignment shall take effect on the first day of the month following the Member's selection.

2.6.3. Contractor shall develop and maintain procedures to ensure continuity of care and support during Member transitions between RAEs. These procedures shall ensure that the quality, quantity, and timeliness of RAE support, Care Coordination, and care delivery are not adversely affected during the transition.

2.7. Attribution, Assignment and Member Engagement

2.7.1. Contractor shall process the attribution assignment list provided by the Department, which includes attribution and assignment information for all Members within Contractor's assigned region, as well as any updates, additions, deletions, or changes to PCMP selection records.

2.7.2. Contractor shall develop and implement policies and procedures to increase the fidelity of Members to their attributed PCMP.

2.7.3. Contractor shall share information about Member utilization patterns outside the PCMP practice with the Member's attributed PCMP.

2.7.3.1. Contractor shall follow up with Members who frequently seek care from Providers other than their attributed PCMP, including urgent care and emergency department (ED) visits. Contractor shall identify barriers to accessing the Member's attributed PCMP, and if appropriate, assist the Member in strengthening their relationship with their current PCMP or changing their attributed PCMP.

2.7.3.2. Contractor shall assist Members who wish to select or change their attributed PCMP by providing a warm handoff to the Enrollment Broker customer contact center. The Department will conduct a quarterly reattribution process to ensure PCMP attributions reflect the Member's strongest relationship with a PCMP.

2.7.3.3. Contractor shall regularly identify Members residing in Nursing Facilities or regional centers. Contractor shall collaborate with these facilities to ensure accurate Member attribution and assist Members in selecting a PCMP, as needed.

2.8. Member Accountability Policies

2.8.1. Contractor shall collaborate with the Department, PCMPs, and Stakeholders to support Member accountability for utilization of health services over time.

2.9. RAE Reassignment Process

2.9.1. Contractor shall recognize that any Member may request reassignment from the RAE serving the Member's PCMP to the RAE serving the Member's county of residence. Such requests must be submitted jointly by the Member and the Member's care coordinator or case manager using the Department provided RAE Reassignment Request Form.

2.9.2. Contractor shall assist Members requesting reassignment by:

2.9.2.1. Providing guidance to Members on completing the RAE Reassignment Request Form.

2.9.2.2. Sharing the completed RAE Reassignment Request Form with the requested RAE.

2.9.2.3. Ensuring that Members considered for reassignment meet all the following criteria:

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

2.9.2.3.2. The Member is receiving a range of mental health and community support services from a Comprehensive Community Behavioral Health Provider (Comprehensive Provider).

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

2.9.2.3.4. The Member has, within the past 12 months, experienced one or more of the following:

2.9.2.3.4.1. Hospitalization for a mental health condition.

2.9.2.3.4.2. Utilization of Colorado Crisis Services.

2.9.2.3.4.3. Involvement with criminal justice system.

2.9.2.3.4.4. Other similar indicators of mental health complexity.

2.9.2.3.5. The Member must also require ongoing therapeutic and community-based services to live stably in the community.

2.9.3. If a reassignment request is approved, the Member's reassignment to the new RAE shall be effective as follows:

2.9.3.1. On the first day of the month following the month in which the Department approves the reassignment request, provided the request is processed in time.

2.9.3.2. On the first day of the second month following the Department's approval if the request is received too late to process in the interChange system for the upcoming month.

2.9.3.3. The Care Management PMPM will transition to the new RAE to which the Member is assigned; no PCMP will be attributed for these Members.

2.9.4. Contractor Responsibilities for Reassignment:

2.9.4.1. Contractor shall comply with the Department's determinations regarding RAE reassignment.

2.9.4.2. Contractor shall develop and implement procedures to ensure a smooth transition of services to the new RAE. These procedures shall ensure that the Member's quality, quantity, and timeliness of care are not affected during the transition.

3. MEMBER ENGAGEMENT

3.1. Contractor shall prioritize Member engagement by incorporating Member feedback and input into the development, implementation, and continuous improvement of all aspects of Contractor's Work.

3.2. Person and Family-Centered Approach

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

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

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

3.2.1.3. Proactive education that promotes the effective utilization of Medicaid benefits and the health care system.

3.2.1.4. Promotion of health and wellness, particularly preventive and healthy behaviors, including but not limited to Colorado state public health initiatives, Department priorities, and Centers for Medicare and Medicaid Services (CMS) Core Measures.

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

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

3.3. Cultural Responsiveness

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

3.3.2. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, Provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in Contractor's service area. Contractor shall create written materials in English and Spanish or any other prevalent language, as directed by the Department or as required by 42 CFR § 438.10.

3.3.3. Contractor shall provide cultural and disability competency training to Contractor staff and make trainings available to Network Providers regarding, at minimum, all of the following:

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

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

3.3.3.3. **PERFORMANCE STANDARD**: 90% of all Contractor's staff shall have completed training in cultural and disability competence annually.

3.3.3.4. **PERFORMANCE STANDARD**: Contractor shall ensure that 90% of Network Providers offer cultural and disability competency training for staff annually or that Network Providers and their staff have the opportunity to participate in Contractor offered cultural and disability competency training on an annual basis.

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

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

3.3.5.1. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, remaining in compliance with Accessibility requirements as described in Section 16.U of this Contract.

3.3.6. Contractor shall provide language assistance services as required by 42 CFR § 438.10, for all Contractor interactions with Members and for all Covered Services and Medicaid covered services delivered by Network Providers. Language assistance services shall include bilingual staff and interpreter services at no cost to any Member. These services shall be provided at all points of contact, in a timely manner, and during all hours of operation. Contractor shall implement technologies for language assistance services in accordance with standards specified by the Department or as otherwise required by applicable law or regulation.

3.3.6.1. Contractor shall make oral interpretation available in all languages and written translation available in each prevalent non-English language, based on U.S. Census Bureau data, available at no cost to any Member.

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

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

3.3.6.2. Contractor shall notify Members verbally and through written notices regarding the Member's right to receive the following language assistance services at no cost, as well as how to access, at minimum, all of the following language assistance services:

3.3.6.2.1. Oral interpretation for any language. Oral interpretation requirements apply to all non-English languages, not just those that are identified as prevalent.

3.3.6.2.2. Written translation in prevalent languages.

3.3.6.2.3. Auxiliary aids and services for Members with disabilities.

3.3.6.3. Contractor shall ensure that language assistance services include the use of auxiliary aids such as Teletypewriters/Telecommunication Device for the Deaf (TTY/TDD) and American Sign Language (ASL).

3.3.6.4. Contractor shall ensure that all Contractor customer service call centers, as per outlined requirements in Section 3.3, can easily access interpreter or bilingual services.

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

3.3.6.6. Contractor shall report on the provision of language assistance services to Members in the Health Equity Plan as required in Section 6.3.8, in a format approved by Contractor and Department, as requested by the Department.

3.3.7. Written Materials for Members

3.3.7.1. Contractor shall ensure that all written materials it creates for distribution to Members meet all noticing requirements of 45 CFR Part 92.

3.3.7.2. Contractor shall ensure that Member communications adhere to the Department's brand standards.

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

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

3.3.7.3.1. 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 Contractor's region.

3.3.7.3.2. 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 help Members understand the information provided.

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

3.3.7.5. Contractor shall write all materials in easy-to-understand language and format and comply with all applicable requirements of 42 CFR § 438.10.

3.3.7.6. Contractor shall comply with all applicable requirements of § 25.5-4-212, C.R.S. including using person-first, plain language best practices. Plain language best practices shall include, but are not limited to, guidelines available at www.plainlanguage.gov.

3.3.7.7. Contractor shall participate in established plain language trainings provided by the Department.

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

3.3.7.9. Contractor shall translate all written information into other non-English languages prevalent in Contractor's assigned region.

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

3.3.7.11. 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/TDD telephone number of Contractor's Member service unit, at no cost.

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

3.3.7.13. In accordance with § 25.5-4-212, C.R.S., Contractor shall define "Member correspondence" as any communication, the purpose of which is to provide notice of an approval, denial, termination, or change to an individual's Medicaid eligibility; to provide notice of the approval, denial, reduction, suspension, or termination of a Medicaid benefit; or to request additional information that is relevant to determining an individual's Medicaid eligibility or benefits.

3.3.7.13.1. Contractor shall submit all templates of Member correspondence, subject to § 25.5-4-212, C.R.S., to the Department for review before distribution. Contractor shall make changes to templates as requested by the Department.

3.3.7.13.2. Member correspondence templates shall be defined as a sample notice that does not include any personal identifiable information.

3.3.7.13.2.1. **DELIVERABLE**: Member correspondence templates

3.3.7.13.2.2. **DUE**: Within 10 Business Days of creation of a new Member correspondence template or an update to an existing template, and prior to distribution to any Members.

3.3.7.13.3. When requested, Contractor shall use Member notices developed by the Department.

3.3.7.13.4. Contractor shall provide to the Department any documentation developed by Contractor for the purposes of Member correspondence within three Business Days after the Department's request.

3.4. Member Communications

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

3.4.2. Contractor shall maintain, staff, and publish the number for a single, toll-free telephone line that Members may call for assistance. Member assistance shall include, but is not limited to, accessing Colorado Medicaid benefits, finding providers, understanding Colorado Medicaid benefits, customer service, requests for Care Coordination support, and filing grievances and appeals.

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

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

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

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

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

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

3.4.3. Contractor may provide additional methods, such as web-based forms, for Members to request assistance from Contractor.

3.4.3.1. Contractor shall collaborate with the Department to establish and define inquiry types that categorize the common questions or reasons Members request assistance.

3.4.3.1.1. Contractor shall record an inquiry type for each inquiry received by Contractor.

3.4.3.1.2. Contractor shall respond to all Member inquiries within two Business Days.

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

3.4.3.2.1. Contractor's Member assistance surveys shall measure, at a minimum, all of the following areas:

3.4.3.2.1.1. Overall satisfaction with the services provided by Contractor

3.4.3.2.1.2. The Member's satisfaction with how Contractor explained the assistance options available to the Member.

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

3.4.3.3. Contractor shall document and implement a clear process for how Contractor shall escalate a Member request for assistance when the Member requests, and when a Contractor staff determines, further support is required to address a Member's needs.

3.4.3.4. Contractor shall submit a Member Assistance Statistics Report in a format agreed upon by the Department and Contractor that includes, at minimum, all of the following information:

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

3.4.3.4.2. Voicemails and other asynchronous methods that Members utilize to submit requests for assistance not returned within one Business Day, in both number and percentage of all requests received.

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

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

3.4.3.4.5. Overall totals for request types and subtypes.

3.4.3.4.5.1. **DELIVERABLE**: Member Assistance Statistics Report

3.4.3.4.5.2. **DUE**: Monthly, within 15 days after the last day of the month for which the report covers

3.4.3.4.6. **PERFORMANCE STANDARD**: 98% compliance with each Member call line contract management requirement each month.

3.4.4. Contractor shall maintain sufficient licenses to connect to the Department's Member Contact Center's (MCC) Customer Relationship Management (CRM) system to easily and quickly transfer Members between Contractor and the MCC, enable Contractor to access the Department's Knowledgebase when responding to Member questions, and collaborate on large-scale Member communication scheduling with the Department.

3.4.4.1. The Department will provide to Contractor an appropriate number of licenses for the Department's CRM agreed upon by Contractor and the Department.

3.4.4.2. Contractor may use the Department's CRM as its primary CRM tool at its discretion; if Contractor does not use the Department's CRM as its primary tool, Contractor shall maintain its own CRM system to meet the requirements of this Contract.

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

3.4.6. General Member Information Requirements

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

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

3.4.6.1.2. Contractor's Email address.

3.4.6.1.3. Contractor's website address.

3.4.6.1.4. State relay information.

3.4.6.1.5. The basic features of the RAE's managed care functions as a PCCM Entity and PIHP.

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

3.4.6.1.7. The region covered by Contractor.

3.4.6.1.8. Medicaid benefits, including:

3.4.6.1.8.1. State Plan benefits provided by the Department.

3.4.6.1.8.2. Capitated Behavioral Health Benefits provided by Contractor.

3.4.6.1.8.3. Information about where and how to obtain counseling and referral services that Contractor does not cover because of moral or religious objections, in compliance with 42 CFR § 438.10(e)(2)(v)(C).

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

3.4.6.1.10. A directory of Network Providers.

3.4.6.1.11. The requirement for Contractor to provide adequate access to Behavioral Health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards defined in Section 5.5.

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

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

3.4.6.2. Contractor shall notify Members when Contractor adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 calendar days prior to the effective date of the policy for any particular service, in compliance with 42 CFR § 438.10(g).

3.4.7. Member Rights

3.4.7.1. Contractor shall have written policies guaranteeing each Member's right to be treated with respect and due consideration for the Member's dignity and privacy.

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

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

3.4.7.2.2. 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.

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

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

3.4.7.2.5. The right to request and receive a copy of the Member's Medical Records and request that they be amended or corrected.

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

3.4.7.2.7. Freely exercise the Member's Rights with Contractor or its Providers treating the Member adversely.

3.4.7.3. Contractor shall post and distribute Member Rights to individuals, including but not limited to:

3.4.7.3.1. Members.

3.4.7.3.2. Member's families, guardians, or caregivers.

3.4.7.3.3. Providers.

3.4.7.3.4. Case workers.

3.4.7.3.5. Stakeholders.

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

3.4.8. Member Handbook

3.4.8.1. Contractor shall work jointly with the Department on a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 CFR § 438.10. The Member Handbook shall include, at a minimum, all of the following:

3.4.8.1.1. Information that enables the Member to understand how to effectively use Medicaid and the ACC.

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

3.4.8.1.3. The amount, duration, and scope of benefits available under this Contract and the MCO contract in sufficient detail to ensure that Members understand the benefits to which they are entitled.

3.4.8.1.4. Access to Benefits

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

3.4.8.1.4.2. Extent to which, and how, Members may obtain benefits, including family planning services and supplies from Out-of-Network Providers.

3.4.8.1.5. Emergency and After Hours Care

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

3.4.8.1.5.1.1. 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 Member, the health of the Member or their unborn child)

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

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

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

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

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

3.4.8.1.5.1.6. The locations of any emergency settings and other locations at which Providers and hospitals furnish emergency services and Post-Stabilization Services covered under the contracts.

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

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

3.4.8.1.7. A statement that prior authorization is not required to receive services from family planning Providers.

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

3.4.8.1.9. Member rights and responsibilities.

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

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

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

3.4.8.1.13. A section with information specific to Contractor's assigned region.

3.4.8.2. Contractor shall submit comprehensive contact information to the Department for inclusion in the Colorado Medicaid Member Handbook. This information shall include, at a minimum:

3.4.8.2.1. Contractor's primary contact phone number(s), email address(es), and physical address(es) for Member inquiries.

3.4.8.2.2. Hours of operation during which Members can access assistance.

3.4.8.2.3. Any other designated contact method and supporting information necessary for resolving Member concerns, as necessary.

3.4.8.2.3.1. **DELIVERABLE**: Colorado Medicaid Member Handbook Contractor contact information

3.4.8.2.3.2. **DUE**: Five Business Days after the Effective Date

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

3.4.8.3.1. **DELIVERABLE**: Update Colorado Medicaid Member Handbook Contractor Contact Information

3.4.8.3.2. **DUE**: 30 day prior to any of Contractor's contact information changes taking effect.

3.4.9. Contractor Website

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

3.4.9.1.1. Contractor's contact information.

3.4.9.1.2. Member rights and handbooks.

3.4.9.1.3. Grievance and Appeal procedures and rights.

3.4.9.1.4. General functions of Contractor.

3.4.9.1.5. Trainings.

3.4.9.1.6. Access to care standards.

3.4.9.1.7. Health First Colorado Nurse Advice Line.

3.4.9.1.8. Colorado Crisis Services information.

3.4.9.1.9. Non-Emergent Medical Transportation (NEMT) benefit information including links for regional Providers and instructions for obtaining rides and submitting requests for mileage reimbursement.

3.4.9.2. For PCMPs and Behavioral Health Providers, Contractor shall make information on Contractor's Network Providers available to Members as a Network Directory in electronic form and in paper form upon request.

3.4.9.2.1. Contractor shall ensure that the electronic Network Directory is updated no later than five Business Days after Contractor receives updated Provider information.

3.4.9.2.2. Contractor shall update the paper Network Directory at least quarterly as required by 42 CFR § 438.10(h)(3).

3.4.9.2.3. Contractor shall include the following information about Network Providers in the Network Directory:

3.4.9.2.3.1. Names, as well as any group affiliations.

3.4.9.2.3.2. Street addresses.

3.4.9.2.3.3. Telephone numbers.

3.4.9.2.3.4. Website addresses, as appropriate.

3.4.9.2.3.5. Specialties, as appropriate.

3.4.9.2.3.6. Whether Network Providers will accept new Members.

3.4.9.2.3.7. The cultural and linguistic capabilities of Network Providers, including languages including, but not limited to, ASL offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the Provider has completed cultural competence training.

3.4.9.2.3.8. Whether Network Providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

3.4.9.2.3.9. Whether the Network Provider offers Covered Services via telehealth.

3.4.9.2.4. Contractor shall submit the Network Directory to the Department.

3.4.9.2.4.1.1. **DELIVERABLE**: Network Directory

3.4.9.2.4.1.2. **DUE**: Five days prior to the Operational Start Date, and within 30 days after changes to the Network Directory

3.4.9.2.5. Contractor shall update the Network Directory within 30 calendar days after receipt from the Department with corrected Provider information discovered during a Secret Shopper Survey, as required by 42 CFR § 438.10(h)(3).

3.4.9.2.5.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Network Directory accuracy score as agreed upon by the Department and MCEs but no less than 80% on the Department's annual audit of the Network Directory or the annual independent Secret Shopper Survey, with the goal that by SFY 2028-29 the accuracy score is no less than 90%. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

3.4.9.2.6. Contractor shall make the Network 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.

3.4.9.2.7. Contractor shall include in the Network Directory information on each of the following Provider types covered under the contract:

3.4.9.2.7.1. Physicians, including specialists.

3.4.9.2.7.2. Hospitals.

3.4.9.2.7.3. Pharmacies.

3.4.9.2.7.4. Mental health and SUD Providers.

3.4.9.3. Contractor shall offer individualized support to Members in finding a PCMP or Behavioral Health Provider, in addition to providing the Network Directory.

3.4.9.4. Contractor shall provide a link to the Department's website on Contractor's website for standardized information such as Member Rights and Colorado Medicaid Member Handbook.

3.4.9.5. Contractor shall provide a statement on Contractor's website that all Member information required in this Section **Error! Reference source not found.** is available in paper form without charge upon request within five Business Days after the Member's request is made.

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

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

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

3.4.10. Termination of Provider Agreement

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

3.4.10.2. Contractor shall provide Members in ongoing Behavioral Health treatment appropriate supports and Care Coordination to prevent exacerbation of a Member's health condition while Contractor works to connect the Member with a new treatment Provider.

3.4.11. Information on Grievance and Appeals Process

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

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

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

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

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

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

3.4.11.1.6. The method for obtaining a State Fair Hearing.

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

3.4.11.1.8. The benefits will continue, when requested by the Member, if the Member files a timely Appeal or State Fair Hearing request.

3.4.11.1.9. Any Appeal rights the State makes available to Providers to challenge the failure of Contractor to cover a service.

3.4.12. Advance Directives

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

3.4.12.2. At the time of initial enrollment, Contractor shall provide written information to adult Members with respect to advance directives policies, which shall include all of the following:

3.4.12.2.1. A description of applicable State law.

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

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

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

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

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

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

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

3.4.13. Other Member Information

3.4.13.1. Contractor shall provide other necessary information to Members and their families, as determined by the Department. This information shall include, but not be limited to, the services provided by EPSDT and how to obtain additional information.

3.4.14. Member Material Review Process

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

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

3.4.14.2.1. **DELIVERABLE**: Notification of large-scale Member communication initiative

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

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

3.4.14.4. The Department may review any Member materials used by Contractor and request changes or redrafting of Member materials as the Department determines necessary to ensure that the language is easy to understand, follows plain language best practices, and that the document aligns with the Department standards. Contractor shall make any changes to the Member materials requested by the Department. This requirement does not apply to individual correspondence that is directed toward a specific Member.

3.4.15. Electronic Distribution of Federally Required Information

3.4.15.1. In order to electronically distribute information required by 42 CFR § 438.10 to Members, Contractor shall meet all of the following conditions:

3.4.15.1.1. The format is readily accessible and complies with modern accessibility standards such as ADA, Sections 504 and 508 of the Rehabilitation Act, and in compliance with the accessibility requirements outlined in Section 16.U of this Contract.

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

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

3.4.15.1.4. The information is consistent with the content and language requirements of 42 CFR § 438.10.

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

3.4.15.2. Contractor shall send an electronic communication, at minimum every six months, to all assigned Members who have consented to receive electronic communications providing Members with information on how Members can update their contact information and enrollment information. When possible, this communication should be combined with Contractor's other communication activities.

3.4.15.2.1. Contractor shall help Members with the process for submitting the Member's updated contact information, renewals, and verifications via PEAK at CO.gov/PEAK or in the Health First Colorado mobile application (free and available from Apple and Google Play) upon the Member's request, depending on Member access to these options.

3.4.15.2.1.1. Contractor shall not:

3.4.15.2.1.1.1. Act on the Member's behalf or in place of registered assisters.

3.4.15.2.1.1.2. Complete and/or sign a Medicaid application or renewal on a Member's behalf, even in the presence of or on the phone with a Member.

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

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

3.4.15.4.1. In the course of providing renewal assistance, Contractor shall not:

3.4.15.4.1.1. Act on the Member's behalf or in place of registered assisters.

3.4.15.4.1.2. Complete and/or sign a Medicaid application or renewal on a Member's behalf, even in the presence of or on the phone with a Member.

3.4.15.4.1.3. Influence a Member who will lose or may lose Medicaid eligibility to enroll in a qualified health plan offered by Contractor or an entity that is connected to Contractor.

3.5. EPSDT Outreach

3.5.1. Contractor shall inform pregnant Members and EPSDT eligible Members, or their families, guardians, or caregivers, about the comprehensive EPSDT program that includes physical, behavioral, oral, and vision health benefits, in accordance with requirements specified in 42 CFR § 441.56 and the State Medicaid Manual Chapter V, Section 5121.

3.5.1.1. Contractor shall inform Members about the EPSDT program generally within 60 days after the Member's initial Medicaid eligibility determination or after a Member regains eligibility following a greater than 12-month period of ineligibility.

3.5.1.2. Contractor shall inform Members about the EPSDT program generally within 60 days after identification of the Member being pregnant.

3.5.1.3. At least one time annually, Contractor shall outreach Members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care."

3.5.1.4. Contractor shall provide to households with EPSDT-eligible Members, including children involved with Child Welfare, at minimum, all of the following information:

3.5.1.4.1. The benefits of preventive health care, including the American Association of Pediatrics' "Bright Futures Guidelines."

3.5.1.4.2. The services available to Members under the EPSDT program.

3.5.1.4.3. Where EPSDT services are available and appointment assistance if requested by Members.

3.5.1.4.4. How to obtain EPSDT services, including those not offered under this Contract.

3.5.1.4.5. How Contractor can provide necessary assistance with scheduling appointments for services.

3.5.1.4.6. EPSDT services are available without cost to the Member.

3.5.1.4.7. How to request necessary transportation, reimbursement for mileage, and transportation scheduling assistance from Contractor or other vendor.

3.5.1.5. Contractor shall be accountable for providing information on EPSDT at least once to households with multiple EPSDT-eligible Members residing in the household. Contractor will not be held accountable for providing EPSDT information to each individual EPSDT-Eligible Member residing in the household.

3.5.1.6. Contractor does not need to inform households more than once in a 12-month period when Members lose and regain Medicaid eligibility during that 12-month period.

3.5.1.7. Contractor's communications about EPSDT shall be delivered using easy-to-understand, plain language best practices.

3.5.1.8. Contractor shall use a combination of oral and written materials to outreach EPSDT-eligible Members, as permitted under the Telephone Consumer Protection Act, including but not limited to:

3.5.1.8.1. Mailed brochures or pamphlets.

3.5.1.8.2. Face-to-face interactions.

3.5.1.8.3. Telephone calls.

3.5.1.8.4. Video conferencing.

3.5.1.8.5. Automated calls.

3.5.1.8.6. Email messages.

3.5.1.8.7. Text/SMS messaging.

3.5.1.9. 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 Academy of Pediatrics' (AAP) "Bright Futures Guidelines."

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

3.5.1.11. Contractor shall employ proven best practices for outreach including:

3.5.1.11.1. Using multiple methods of communication.

3.5.1.11.2. Staggering message delivery to different days of the week or hours of the day.

3.5.1.11.3. Limit telephone (including automated) calls and text messages to between the hours of 8:00 AM MST and 9:00 PM MST. Monday through Friday and 10:00 AM MST through 4:00 PM MST Saturday or Sunday.

3.5.1.11.4. Attempt to reach Members more than once through multiple methods as outlined in Section 3.5.1.8.

3.5.1.11.5. Target outreach activities to particular "at risk" groups, to be defined by Contractor and with final approval by 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 two years might benefit most from oral methods.

3.5.1.12. 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:

3.5.1.12.1. Head Start.

3.5.1.12.2. Early Intervention under the Individuals with Disabilities Education Act (IDEA).

3.5.1.12.3. WIC.

3.5.1.12.4. School health programs of state and local education agencies.

3.5.1.12.5. Social services programs under Title XX.

3.5.1.13. Contractor shall collaborate with the Department on best practices for educating Members about EPSDT and for outreaching EPSDT-Eligible Members to improve adherence to the AAP "Bright Futures Guidelines."

3.5.1.14. 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.

3.5.1.15. Contractor shall submit to the Department an annual EPSDT Outreach Plan that describes processes utilized to effectively inform Member's as required, generally, within 60 days after the Member's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

3.5.1.15.1. **DELIVERABLE**: EPSDT Outreach Plan

3.5.1.15.2. **DUE**: Annually, on July 31

3.5.1.16. 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 shall include descriptions of Contractor's communication methods for outreach and individual Member reporting of completed outreach activities and attempted outreach activities.

3.5.1.16.1. **DELIVERABLE**: EPSDT Outreach Report

3.5.1.16.2. **DUE**: Quarterly, 45 days after the end of the quarter the report covers

3.5.1.16.3. **PERFORMANCE STANDARDS**:95% of children and youth newly determined eligible for Medicaid have been outreached about EPSDT within 60 days after the Member's Medicaid eligibility determination.

3.5.1.16.4. **PEROFRMANCE STANDARD**: 95% of children and youth who have not utilized EPSDT services in the previous 12 months have been outreached about engagement in preventive care in accordance with "AAP Bright Futures" guidelines.

3.6. Marketing

3.6.1. Contractor shall not engage in any Marketing Activities, as defined in 42 CFR § 438.104, during the Start-Up Period.

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

3.6.3. Contractor shall submit all materials relating to Marketing Activities to the Department and shall allow the Department and any councils overseen by the Department, including the State Medical Assistance and Services Advisory Council, to review any materials Contractor proposes to use for Marketing Activities before distributing the materials. The Department may require changes to any materials before Contractor may distribute those materials or may disallow the use of any specific materials in the Department's sole discretion.

3.6.4. 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.

3.6.5. Contractor shall distribute the Marketing materials to its entire region as defined by the Contract.

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

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

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

3.6.9. Contractor shall ensure that Marketing materials do not contain any assertion or statement, whether written or oral, that Contractor is endorsed by the CMS, the federal or state government, or similar entity.

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

3.7. Health Needs Survey

3.7.1. The Department has developed a Health Needs Survey to be completed by Members as part of the eligibility and onboarding process to identify immediate Member health needs.

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

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

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

3.7.5. Contractor shall ensure Members who have completed the Health Needs Survey have been outreached as expeditiously as the Member's reported need requires.

3.7.6. The Department reserves the right to adjust the Health Needs Survey during the term of the Contract. Contractor shall assist the Department in improving the Health Needs Survey and to identify Members' chronic conditions, emerging health risks and opportunities for intervention, health-related social needs and Care Coordination. Contractor shall work with

Department to smoothly implement any new tools or aggregate Member information to better meet the objectives of the Health Needs Survey and the ACC.

3.8. Promotion of Member Health and Wellness

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

3.8.2. Contractor shall develop, implement, and promote evidenced-based wellness and prevention programs for Contractor's Members. Contractor shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by the Department such as case management programs for pregnancy and postpartum, diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), pediatric wellness, and overall health promotion programs, which include tobacco cessation and behavioral health screenings and follow-up care. Contractor shall participate in other state public health initiatives at the direction of the Department.

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

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

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

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

3.8.6. Member Incentives

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

3.8.6.2. Contractor shall have systems capable of implementing a Member Incentive Program developed by the Department.

3.8.6.3. Contractor shall ensure that all incentives are cost-effective, align with best practices, and have a linkage to the Department's goals for the ACC or Value-Based Payment strategies.

3.8.6.3.1. The Department will share the ACC or Value-Based Payment goals with Contractor.

3.8.6.4. For the Member Incentive Program, Contractor shall provide to participating Members incentives that may include cash, gift cards for specific retailers, vouchers for a farmers market, gym memberships, or other incentives approved by the Department and permitted under federal guidance.

3.8.6.4.1. Incentives shall not, in a given Fiscal Year for any one Member, exceed a total monetary value as established by the Department.

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

3.8.6.4.3. Contractor shall partner with the Department to develop and implement at least one Member Incentive Program designed to address one of the Department's priority areas, which may include, at minimum, any of the following:

3.8.6.4.3.1. Increase the timeliness of prenatal care.

3.8.6.4.3.2. Childhood immunizations.

3.8.6.4.3.3. Address obesity.

3.8.6.4.3.4. Prevent diabetes.

3.8.6.4.3.5. Support smoking cessation.

3.8.6.4.3.6. Contingency Management for SUD.

3.8.6.5. Contractor shall educate Members who are interested in participating in a Member Incentive Program or who want to receive another form of compensation from Contractor on the potential implications for the Member's Medicaid eligibility and taxes in accordance with Department guidance.

3.8.6.6. Contractor shall report to the Department, at least annually, the results of the Member Incentive Program in the prior 12 months, including, at minimum, all of the following metrics:

3.8.6.6.1. The incentive(s) offered.

3.8.6.6.2. The number of Members in the Member Incentive Program's target population, as determined by Contractor.

3.8.6.6.3. The number of Members who received any incentive payment, and the number who received the maximum amount as a result of participation in the Member Incentive Program.

3.8.6.6.4. The total value of the incentive payments.

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

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

3.8.6.7. Contractor shall deliver the Member Incentive Program Report to the Department for review and approval.

3.8.6.7.1. **DELIVERABLE**: Member Incentive Program Report

3.8.6.7.2. **DUE**: Annually, as determined by the Department

4. GRIEVANCES AND APPEALS

4.1. Overview

4.1.1. In accordance with 42 CFR § 438 Subpart F and 10 CCR 2505-10, Section 8.209 of the Medicaid state rules for Managed Care Grievances and Appeals Processes, Contractor shall

have a Grievance and Appeal system, as well as processes to collect and track information about Grievances and Appeals.

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

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

4.1.4. In compliance with 42 CFR § 438.414 and 42 CFR § 438.10(g)(2)(xi), Contractor shall inform Network Providers and Subcontractors, at the time Network Providers and Subcontractors enter into a contract with Contractor, about the following:

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

4.1.4.1.1. The requirements and timeframes for filing.

4.1.4.1.2. The availability of assistance with filing.

4.1.4.1.3. The toll-free number to file orally.

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

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

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

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

4.1.5. With the written consent of the Member, Contractor shall allow a Provider or an authorized representative to request an Appeal, file a Grievance, or request a State Fair Hearing, on behalf of a Member. When Member is used throughout this Section 4, it includes Providers and authorized representatives consistent with this paragraph, with the exception that Providers cannot request continuation of benefits.

4.2. Quality of Care Grievances

4.2.1. Contractor shall establish and maintain a Quality of Care Grievance (QOCG) process through which Members may express dissatisfaction about any matter related to this Contract other than an Adverse Benefit Determination. Expressions of dissatisfaction include, at minimum, any of the following:

4.2.1.1. Concern about having been misdiagnosed.

4.2.1.2. Concern about not receiving appropriate treatment.

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

4.2.1.4. Concern about receiving Covered Services for which the quality provided by the health plan or Provider does not meet professionally recognized standards of health care,

including health care services not provided to the Member, or services provided in inappropriate settings.

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

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

4.2.3.1. Contractor shall document in Contractor's QOCG management system the response and any solutions Contractor has offered to the party that submitted the QOCG.

4.2.4. Contractor shall have processes and procedures to make information about the QOCG process, including how to file a QOCG, available to all Members and the QOCG information is provided to all Network Providers and Subcontractors, including Providers under a single case agreement.

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

4.2.5.1. Contractor shall provide a Member with written notice of receipt of a QOCG within two Business Days of Contractor learning of the QOCG.

4.2.6. Contractor shall not discourage the filing of QOCGs.

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

4.2.7.1. Document the date the incident occurred, as well as the date and time of Contractor's receipt of the QOCG.

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

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

4.2.7.4. Refer QOCGs to Contractor's peer review committee when this venue is available and appropriate. Contractor shall manage peer review deliberations and results as set forth in §§ 12-30-204 and 12-30-205, C.R.S. When a QOCG has been referred to peer review, Contractor shall inform the reporting individual of this in writing, including the provisions of §§ 12-30-204 and 12-30-205, C.R.S., which will limit disclosure of the results.

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

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

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

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

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

4.2.7.9. Resolve the QOCG and provide written notice to the Member of the resolution, per 42 CFR § 438.408.

4.2.7.9.1. **PERFORMANCE STANDARD**: Contractor shall resolve 90% of QOCGs within 90 calendar days from the date the Member files the QOCG. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

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

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

4.2.7.10.2. Contractor shall provide the Department sufficient documentation to justify the need for an extension, if requested to by the Department.

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

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

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

4.2.8. QOCG Resolution

4.2.8.1. Contractor shall consider a QOCG as resolved when the following conditions are met:

4.2.8.1.1. The QOCG has reached a conclusion regarding the submitted QOCG; and

4.2.8.1.2. Contractor has provided a letter or email notice, in accordance with the minimum standards of notice defined in C.F.R. 438.10, to the Member with the following information, so long as there is no conflict with §§ 12-30-204 and 12-30-205, C.R.S.:

4.2.8.1.2.1. Conclusion of the investigation.

4.2.8.1.2.2. The date of Contractor's conclusion of the investigation.

4.2.8.2. Contractor shall not consider or report to the Member that a QOCG is resolved when Contractor has only escalated a QOCG within Contractor's organization. Contractor's investigation must be completed fully to be considered as resolved.

4.2.8.3. Contractor shall submit to the Department documentation of a QOCG resolution and any documented recommended solutions upon the Department's request. If the Department determines the solution to be insufficient or otherwise unacceptable, it may direct Contractor to propose a different solution or follow a Department-specified solution.

4.2.8.4. Contractor shall inform a reporting individual who is dissatisfied with the resolution of the QOCG that they may bring the unresolved QOCG to the Department for review and decision making. The Department's decision on a QOCG is final.

4.2.9. Contractor shall notify the Department within two Business Days of Contractor receiving QOCG cases or becoming aware of incidences involving Members that include, but are not limited to, egregious patient safety concerns, Member death, or cases with potential to generate public attention. Contractor shall report these cases using a process and template provided by the Department.

4.2.9.1. **DELIVERABLE**: Immediate Patient Safety Concern Notice

4.2.9.2. **DUE**: Within two Business Days after Contractor is made aware of the Immediate Patient Safety Concern

4.2.10. Contractor must include in its QOCG process specific procedures to rapidly assess and evaluate within 72-hours any QOCGs that involve an imminent and serious threat to the health or safety of the Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function.

4.2.10.1. Contractor's procedures for addressing expedited QOCGs shall include providing notice to the Member within 72 hours in a method that best suits the needs of the Member. Contractor's notice to the Member shall include, but is not limited to:

4.2.10.1.1. Update on status of Contractor's assessment and evaluation of the QOCG.

4.2.10.1.2. Documentation of the date and time the QOCG was received.

4.2.10.1.3. Identification of alternative resources available to the Member based upon the Member's condition and to address the Member's safety.

4.2.10.2. Contractor shall provide a monthly report to the Department on activities related to expedited QOCGs in a Department specified template.

4.2.10.3. Contractor shall exhaust all reasonable efforts to address the imminent and serious threat to the health or safety of the Member within 72 hours of receiving the QOCG.

4.2.10.3.1. Contractor shall resolve any additional investigation outside of the imminent and serious threat to the health or safety of the Member within the requirements established in this section and in accordance with 42 CFR § 438.408.

4.2.11. Contractor shall document each QOCG, including expedited QOCGs, in a QOCG Summary Report to be sent to the Department. This report shall include, at a minimum:

4.2.11.1. Contact information for the reporting individual.

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

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

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

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

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

4.2.11.7. Evidence of the QOCG resolution.

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

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

4.2.12. Contractor shall submit the QOCG Summary Report to the Department for review and approval in a format agreed upon by Contractor and the Department.

4.2.12.1. **DELIVERABLE**: QOCG Summary Report

4.2.12.2. **DUE**: Monthly, by the 10th Business Day after the end of the reporting month.

4.2.13. If the Department is contacted by a Member, advocates, the Health First Colorado Managed Care Ombudsman, or other individuals/entities with a QOCG regarding concerns about the care or lack of care a Member is receiving, Contractor shall begin processing the QOCG upon notification by the Department using Contractor's QOCG processes and procedures.

4.2.13.1. Contractor shall keep the Department informed about progress on resolving concerns and shall advise the Department of final resolution through a process determined by the Department.

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

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

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

4.2.15. The Department may share information about QOCG investigations with Contractor.

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

4.3. Notice of Adverse Benefit Determination

4.3.1. When Contractor makes an Adverse Benefit Determination as described in 42 CFR § 438.400, Contractor shall send to the Member a notice of Adverse Benefit Determination that meets the following requirements:

4.3.1.1. Is in writing.

4.3.1.2. Complies with the Member correspondence requirements of § 25.5-4-212(3), C.R.S:

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

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

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

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

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

4.3.1.2.6. Clearly conveys the purpose of the Member correspondence, the action or actions being taken by the Department or its designated entity, if any, and the specific action or actions that the Member must or may take in response to the correspondence.

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

4.3.1.2.8. Includes contact information for Member questions.

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

4.3.1.3. Complies with the language and format requirements of 42 CFR § 438.10, including but not limited to:

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

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

4.3.1.3.3. Is in an easily understood language and format.

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

4.3.1.4. Explains the Adverse Benefit Determination Contractor or its Subcontractor has taken or intends to take.

4.3.1.5. Explains the reasons for the Adverse Benefit Determination.

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

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

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

4.3.1.9. Describes how a Member can Appeal.

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

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

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

4.3.1.13. Explains how each dimension of the most recent edition of American Society of Addiction Medicine (ASAM) criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient SUD services.

4.3.1.14. **PERFORMANCE STANDARD**: 95% of Notices of Adverse Benefit Determinations sent to Members use the template provided by the Department.

4.3.2. Contractor shall have policies and procedures to ensure that decision-makers take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

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

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

4.3.3.2. At least five days prior to the date of action, if Contractor has verified information indicating probable beneficiary fraud.

4.3.3.3. By the date of Adverse Benefit Determination when any of the following occur:

4.3.3.3.1. The Member has died.

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

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

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

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

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

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

4.3.3.3.8. The notice involves an Adverse Benefit Determination with regard to preadmission screening requirements.

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

4.3.3.4. On the date of Adverse Benefit Determination when the Adverse Benefit Determination is a denial of payment.

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

4.3.3.5.1. Contractor may extend the seven day standard authorization notice timeframe up to 14 additional days if the Member or the Provider requests extension, or if Contractor

justifies a need for additional information and shows how the extension is in the Member's best interest.

4.3.3.5.2. For Members under the age of 21 seeking authorization for residential services, Contractor shall take no longer than 14 calendar days for standard authorizations requiring an Enhanced Standardized Assessment to determine whether to deny or limit residential services.

4.3.3.5.2.1. Contractor may extend the 14 calendar day service authorization notice timeframe for up to fourteen additional days for residential services for Members under the age of 21 that require an Enhanced Standardized Assessment if the Member or the Provider requests extension; or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

4.3.3.5.3. If Contractor extends the seven or 14 day service authorization notice timeframe, it must give the Member written notice of the reason for the extension and inform the Member of the right to file a Grievance if the Member disagrees with the decision.

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

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

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

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

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

4.4. Handling Appeals for the Capitated Behavioral Health Benefit

4.4.1. Contractor shall handle Appeals of Adverse Benefit Determination for the Capitated Behavioral Health Benefit, in compliance with 42 CFR § 438.400.

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

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

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

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

4.4.4.2. The Grievance or Appeal involves clinical issues.

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

4.4.5.1. Within 60 days after the date of Contractor's notice of Adverse Benefit Determination.

4.4.6. Contractor shall have policies and procedures to ensure that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals.

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

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

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

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

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

4.4.12. Contractor shall take no punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, in accordance with 42 CFR § 438.410.

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

4.4.14. Continuation of Benefits and Services During an Appeal

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

4.4.14.1.1. The Member files the request for an appeal within 60 days after the date of Contractor's notice of Adverse Benefit Determination in accordance with 42 CFR § 438.402 (c)(2)(ii).

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

4.4.14.1.2.1. Ten days after Contractor mailed the notice of Adverse Benefit Determination.

4.4.14.1.2.2. The intended effective date of Contractor's proposed Adverse Benefit Determination.

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

4.4.14.1.4. The services were ordered by an authorized Provider.

4.4.14.1.5. The authorization period has not expired.

4.4.14.2. Contractor shall provide Members with a continuation of benefits during an Appeal or State Fair Hearing through the decision and shall not recoup from Members the cost of any benefits or services that were continued during the appeals process.

4.4.14.2.1. In alignment with 42 CFR 438.420, a continuation of benefits during an Appeal or State Fair Hearing is only available in the case of a termination, suspension, or reduction of previously authorized services. The expiration of previously authorized services shall not be considered a termination, reduction, or suspension, and therefore not eligible for a continuation during the Appeals process.

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

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

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

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

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

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

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

4.4.15. Resolution and Notification of Appeals

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

4.4.15.1.1. For standard resolution of an Appeal and notice to the affected parties, ten Business Days after the day Contractor receives the Appeal.

4.4.15.1.2. **PERFORMANCE STANDARD**: 95% of Appeals shall be resolved within 10 business days after the day the Appeal was received.

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

4.4.15.2.1. Contractor shall provide the Member with written notice within two days after the extension of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member.

4.4.15.3. Contractor shall establish and maintain an expedited review process for Appeals when Contractor determines from a request from the Member or when the Network Provider indicates, in making the request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

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

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

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

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

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

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

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

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

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

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

4.5. State Fair Hearing

4.5.1. Contractor shall allow a Member to request a State Fair Hearing after the Member received notice that Contractor has upheld the Adverse Benefit Determination.

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

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

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

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

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

4.5.5. Expedited State Fair Hearing

4.5.5.1. When the Appeal is heard first through 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 after the Department's receipt of a hearing request for a denial of service that:

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

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

4.6. Health First Colorado Managed Care Ombudsman

4.6.1. Contractor shall utilize and refer Members to the Health First Colorado Managed Care Ombudsman to assist, at minimum, with all of the following:

4.6.1.1. Problem-solving.

4.6.1.2. Grievance resolution.

4.6.1.3. In-plan and State Fair Hearing Appeals.

4.6.1.4. Referrals to Community resources, as appropriate.

4.6.2. Contractor shall share Protected Health Information (PHI), with the exception of psychotherapy notes and SUD-related information, with the Ombudsman upon the Ombudsman's request, without requiring a signed release of information or other permission from the Member, unless Contractor has previously obtained written and explicit instructions from the Member not to share information with the Ombudsman.

4.6.3. Contractor shall create a policy outlining the requirements of the Ombudsman for Medicaid Managed Care and how PHI is shared that can be easily distributed to Network Providers, Subcontractors, advocates, families, and Members.

4.7. Adverse Benefit Determination Reporting

4.7.1. Contractor shall submit an Adverse Benefit Determination Appeals Report to the Department or Department designee in a format and cadence determined by the Department.

4.7.1.1. **DELIVERABLE**: Adverse Benefit Determination Appeals Report

4.7.1.2. **DUE**: 45 days after the end of the reporting quarter

5. NETWORK DEVELOPMENT AND ACCESS STANDARDS

5.1. Establishing a Network

5.1.1. Contractor shall create, administer, and maintain a network of PCMPs and a network of Behavioral Health Providers, building on the Department's current network of Medicaid Providers, to serve the needs of Contractor's Members.

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

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

5.1.3. Contractor shall ensure that its contracted networks are capable of serving all Members, including contracting with Providers with specialized training and expertise across all ages,

levels of ability, gender identities, languages, sexual orientation, and cultural identities. Contractor's networks shall include, at minimum, all of the following list of safety net Providers:

5.1.3.1. Public and Private Providers, including independent practitioners.

5.1.3.2. Federally Qualified Health Centers (FQHC).

5.1.3.3. Rural Health Clinics (RHC).

5.1.3.4. Comprehensive Providers.

5.1.3.5. Essential Behavioral Health Safety Net Providers (Essential Providers).

5.1.3.6. SUD Providers at each level defined by ASAM.

5.1.3.7. School Based Health Centers (SBHC).

5.1.3.8. Indian Health Care Providers.

5.1.3.9. Essential Community Providers (ECP).

5.1.3.10. Providers of High Intensity Outpatient (HIOP).

5.1.3.11. Providers capable of billing both Medicare and Medicaid.

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

5.1.4.1. The anticipated number of Members.

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

5.1.4.3. The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the Covered Services.

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

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

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

5.2. Provider Selection and Contracting

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

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

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

5.2.2.1. Contractor shall ensure that its Provider selection policies and procedures, consistent with 42 CFR § 438.12, do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

5.2.3. Contractor shall not discriminate against Providers acting within the scope of the Provider's license or certification under applicable state law, solely on the basis of that license or certification in accordance with 42 CFR § 438.12(a)(1).

5.2.4. Contractor shall comply with any additional Provider selection requirements established by the Department.

5.2.4.1. Contractor may deny Provider selection based on Contractor's own credentialing policies and procedures, so long as Contractor is compliant with requirements established by the Department, at any point during the contracting and credentialing process.

5.2.5. If Contractor declines to include individual or groups of Providers in its Provider network, Contractor shall give the affected Providers written notice of the reason for its decision in accordance with 42 CFR § 438.12.

5.2.6. Contractor shall complete the contracting processes or deny network admission within 90 days after Contractor receives a Provider's written request to contract with Contractor for at least 90% of all Provider requests.

5.2.6.1. Within the 90 day processing timeline, Contractor shall complete the credentialing and contracting processes or deny network admission within 60 days after receiving a completed application.

5.2.6.2. Contractor may deny a Provider's application from the contracting process if a Provider's application is not complete within 80 days after Contractor receives a Provider's written request to contract with Contractor. Contractor shall notify the Provider if the application is not complete prior to denial of the application.

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

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

5.2.6.4. Contractor shall respond to all Provider inquiries related to a Provider's application or contract within two business days.

5.2.6.4.1. Contractor shall submit to the Department on a monthly basis, the Contracting and Provider Responsiveness Report that includes data on Provider contracting timeliness and responsiveness to Providers using the Department defined format.

5.2.6.4.1.1. **DELIVERABLE**: Contracting and Provider Responsiveness Report

5.2.6.4.1.2. **DUE**: Monthly, on the 15th of the month following the reporting period

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

5.2.8. Contractor shall ensure that its network includes Providers who meet ADA access standards and communication standards, or Contractor shall offer alternative locations that meet these standards.

5.2.9. Contractor shall allow each Member to choose a PCMP and Behavioral Health professional to the extent possible and appropriate.

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

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

5.2.12. Contractor shall document its relationship with and requirements for each PCMP and Behavioral Health Provider in Contractor's network in a written contract.

5.2.13. Contractor shall offer contracts to all willing and qualified FQHCs, Comprehensive Providers, RHCs, and Indian Health Care Providers located in Contractor's assigned region.

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

5.2.15. Contractor shall terminate from Contractor's network any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under title XIX, title XVIII, or title XXI.

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

5.3. PCMP Network

5.3.1. Contractor shall only enter into written contracts with Primary Care Medical Providers that meet the following criteria to qualify as a PCMP:

5.3.1.1. Enrolled as a Colorado Medicaid Provider.

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

5.3.1.3. Practitioner holds a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or Nurse Practitioner (NP) provider license.

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

5.3.1.4.1. Behavioral Health Entities and HIV/infectious disease practitioners may qualify as PCMPs with Contractor's approval if all other PCMP criteria are met.

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

5.3.1.5.1. Physician (Code 05).

5.3.1.5.2. Osteopath (Code 26).

5.3.1.5.3. FQHC (Code 32).

5.3.1.5.4. RHC (Code 45).

5.3.1.5.5. School Health Services (Code 51).

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

5.3.1.5.7. Clinic-Practitioner Group (Code 16).

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

5.3.1.6. Provides Care Coordination.

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

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

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

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

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

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

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

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

5.3.3. Contractor shall offer contracts to all willing and qualified PCMP Practice Sites located within Contractor's assigned region that meet the criteria for being a PCMP.

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

5.3.4. Contractor shall follow all processes established by the Department to ensure that all PCMPs and Behavioral Health Providers are appropriately affiliated as RAE Network Providers in the interChange system. In addition, Contractor shall submit, in a manner, format and

frequency determined by the Department, information relating to all newly contracted PCMPs and Network Providers within contracted PCMP sites. Contractor shall not restrict the Member's free choice of Providers that deliver family planning services and supplies.

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

5.4. Behavioral Health Provider Network

5.4.1. Contractor shall establish and maintain a statewide network of Behavioral Health Providers that spans inpatient, outpatient, and all other covered mental health and SUD services.

5.4.2. Contractor shall maintain a network of Providers that is sufficient to provide adequate access to all services covered under the Capitated Behavioral Health Benefit for all Members, including those with limited English proficiency or physical or mental disabilities in accordance with 42 CFR § 438.206(b)(1).

5.4.3. Contractor shall only enter into written contracts with Behavioral Health Providers that are enrolled as Colorado Medicaid Providers.

5.4.3.1. When developed by the Department and the Behavioral Health Administration (BHA), Contractor shall use the Universal Contracting provisions as established in § 25.5-5-402, C.R.S on a timeline agreed upon by Contractor and the Department. Per § 25.5-5-402, C.R.S inclusion of the Universal Contracting provisions does not preclude Contractor from incorporating other terms to drive value and accountability.

5.4.3.2. Contractor shall collaborate with the Department and the BHA on the implementation of the Universal Contracting provisions and ongoing process improvement activities to ensure the universal contracting provisions are achieving the intended goals and objectives.

5.4.4. Contractor shall establish and manage an adequate network of Providers of High Intensity Outpatient services to ensure Members have access to services that can stabilize and support them in the community.

5.4.5. Contractor shall only contract with Providers of residential SUD and inpatient SUD services that provide or have processes and procedures to provide access to medication assisted treatment.

5.4.6. Contractor shall establish and manage an adequate network of Providers to serve Members who are justice-involved. This includes contracting with Department of Corrections and Department of Youth Services approved treatment Providers.

5.4.7. Contractor shall not enroll Indian Health Service (IHS)/Tribal 638 Providers in its Specialty Behavioral Health Provider Network. Contractor's Network Providers shall serve tribal Members who seek Covered Services, as defined in Section 10 and Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses. When Medicaid services are sought from IHS/Tribal 638 providers, those Providers shall bill the Department's fiscal agent.

5.4.8. Single Case Agreements

5.4.8.1. Contractor shall enter into single case agreements with willing Providers of Behavioral Health services enrolled in Colorado Medicaid when Contractor cannot provide a Covered Service through its contracted Provider network within the timeliness standards of this Contract and a Member needs access to a Medically Necessary, Covered Service.

5.4.8.1.1. Contractor shall consider any Behavioral Health Provider enrolled in Colorado Medicaid for a single case agreement.

5.4.8.1.2. Contractor may refuse to offer single case agreements based on factors of Provider rate and quality concerns.

5.4.8.1.3. Contractor shall execute single case agreements within 14 calendar days of a Member's or Provider's submission of a written request for a single case agreement with an identified, Provider.

5.4.8.1.3.1. **PERFORMANCE STANDARD**: 90% of single case agreements shall be executed within 14 calendar days of a Member's or Provider's submission of a written request for a Single Case Agreement with an identified, Medicaid-enrolled Provider.

5.4.8.1.4. Contractor shall not require Providers that enter into single case agreements to serve additional Members.

5.4.8.1.5. Contractor shall offer both in- and out-of-network Providers assistance in navigating Contractor's single case agreement process.

5.4.8.1.6. Contractor shall ensure all Care Coordination staff and staff who provide Member and Provider support are trained in the single case agreement process.

5.4.8.2. 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 455.400-470.

5.4.9. Behavioral Health Provider Credentialing and Re-credentialing

5.4.9.1. Contractor shall have documented procedures for credentialing and re-credentialing Network Behavioral Health Providers that is publicly available to Providers upon request. The documented procedures shall include Contractor's timeframes for the credentialing and re-credentialing processes.

5.4.9.1.1. Contractor shall submit the Provider Credentialing Policies and Procedures to the Department in a format to be determined by the Department.

5.4.9.1.1.1. **DELIVERABLE**: Provider Credentialing Policies and Procedure.

5.4.9.1.1.2. **DUE**: May 1, 2025

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

5.4.9.2.1. 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.

5.4.9.2.1.1. Providers who are issued a provisional license and are enrolled with Medicaid are considered to be in good standing.

5.4.9.2.1.2. Contractor shall contract with and reimburse Providers with provisional licenses who are enrolled with Medicaid.

5.4.9.2.1.3. Contractor shall use the Council for Affordable Quality Healthcare (CAQH) ProView® application throughout the term of the Work to collect data from individual Providers as necessary to complete the credentialing and recredentialing processes.

5.4.9.2.1.4. Contractor shall use the CAQH VeriFide™ application throughout the term of the Work to perform Provider primary source verification for the credentialing and recredentialing processes.

5.4.9.2.1.5. Contractor may not require any additional documentation from individual Providers for the purposes of credentialing, unless the purpose of the request is to obtain a clean file.

5.4.9.2.2. 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.

5.4.9.3. Contractor shall credential all contracted Providers and ensure that re-credentialing of all individual behavioral health practitioners occurs, at minimum, every three years.

5.4.9.4. The Department may switch to a centralized credentialling process during the term of this Contract. Upon notification from the Department, Contractor shall ensure compliance with the following requirements if this happens:

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

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

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

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

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

5.4.9.4.6. Contractor shall ensure that the re-credentialing status has been updated for all individual Behavioral Health practitioners, at minimum, every three years.

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

5.4.11. Contractor may choose to terminate a Provider from Contractor's network for cause, which may include quality or performance issues, or Contractor may choose to terminate a Provider without cause.

5.4.12. Contractor shall ensure that all laboratory-testing sites providing services under the Work have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

5.5. Access to Care Standards

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

5.5.1.1. Serve all primary care and Care Coordination needs.

5.5.1.2. Serve all Behavioral Health needs.

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

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

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

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

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

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

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

5.5.7. Contractor shall ensure that its Provider Network complies with the time and distance standards in the following table:

Table A:

Provider Type	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)
Acute Inpatient Hospital (Emergency services available 24/7	20	10	45	30	80	60	75	60	110	100
Primary Care - Adult	20	10	30	15	40	20	60	30	90	60

Primary Care - Pediatric	20	10	30	15	40	20	60	30	90	60
Outpatient Clinical Mental Health (Licensed, accredited, or certified professionals) - Adult	20	10	30	15	40	20	60	30	90	60
Outpatient Clinical Mental Health (Licensed, accredited, or certified professionals) - Pediatric	20	10	30	15	40	20	60	30	90	60
General Pediatric Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	110	100
General Adult Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	110	100
SUD Treatment Practitioner - Adult	20	10	30	15	40	20	60	30	90	60
SUD Treatment Practitioner - Pediatric	20	10	30	15	40	20	60	30	90	60

5.5.8. Contractor shall ensure that its Provider Network has a sufficient number of Network Providers per Provider Type listed in Table A so that each Member has a choice of at least two practitioners of the same Provider Type within the maximum time or the maximum distance for the Member's county classification. For Micro, Rural, and CEAC counties, the Department may adjust this requirement based on the number and location of available Providers.

5.5.8.1. In the event that there are less than two practitioners that meet the Provider Type standards within the defined area for a specific Member, then Contractor shall not be bound by the requirements of Section 5.5.8 for that Member.

5.5.8.1.1. **PERFORMANCE STANDARD**: At least 90% of Members have choice of at least two Network Providers per Provider Type listed in Table A within the maximum time or the maximum distance for the Member's county classification.

5.5.8.1.2. **PERFORMANCE STANDARD**: At least 95% of Members have at least one Network Provider per Provider Type listed in Table A within the maximum time or the maximum distance for the Member's county classification.

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

5.5.8.3. Contractor shall ensure that its Provider network meets the following practitioner to Member ratios:

5.5.8.3.1. Adult primary care Providers: One practitioner per 1,200 adult Members.

5.5.8.3.2. Mid-level adult primary care Providers: One practitioner per 1,200 adult Members.

5.5.8.3.3. Pediatric primary care Providers: One PCMP Provider per 1,200 child Members.

5.5.8.3.4. Adult mental health Providers: One practitioner per 1,200 adult Members.

5.5.8.3.5. Pediatric mental health Providers: One practitioner per 1,200 child Members.

5.5.8.3.6. Adult SUD Providers: One practitioner per 1,200 adult Members.

5.5.8.3.7. Pediatric SUD Providers: One practitioner per 1,200 child Members.

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

5.5.8.4.1. Contractor may include as part of Network Adequacy reporting Network Providers that have not submitted any Medicaid claims within the previous 18 months if the Provider attests that they have the capacity and willingness to provide services to Members, but no Members have accessed care with them in the previous 18 months.

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

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

5.5.8.6. Contractor may use the Department's template to request an exception from the maximum time and distance standards when a county has insufficient number of Providers/facilities to meet the standard network adequacy requirements for a specific Provider type.

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

5.5.8.6.1.1. **DELIVERABLE**: County Service Exception

5.5.8.6.1.2. **DUE**: Upon identification of insufficient Providers/facilities in a county to meet time or distance requirements

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

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

5.5.9.2. Outpatient Follow-up Appointments – within seven calendar days after Member's discharge from a hospitalization.

5.5.9.3. Routine Primary Care, Non-urgent Symptoms – within seven Business Days after the request.

5.5.9.4. Well Care Visit – within 30 calendar days after the Member's request, unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Bright Futures schedule.

5.5.9.5. The following additional timely access to care standards apply only to the Capitated Behavioral Health Benefit

5.5.9.5.1. Emergency Behavioral Health Care – by phone within 15 minutes after the Member's initial contact, including TTY/TDD accessibility; in person within one hour after Member contact in Urban and suburban areas, in person within two hours after Member contact in rural and frontier areas.

5.5.9.5.2. High-Fidelity Wraparound services for children and youth – children and youth determined eligible for Enhanced High-Fidelity Wraparound services through the Enhanced Standardized Assessment will initiate services within 30 calendar days of Contractor's referral of the Member to a Provider of Enhanced High-Fidelity Wraparound services.

5.5.9.5.3. Medication Assisted Treatment – evaluation for treatment within 72 hours after a Member's request.

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

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

5.5.9.6. As agreed, upon by Contractor and the Department, Contractor shall meet updated timely access to care standards that align with BHA network adequacy and access to care methodologies. This will likely include the updated service categories outlined in § 27-50-300, C.R.S. or specific requirements for safety net services or Providers.

5.5.9.7. Contractor shall take actions necessary to ensure that all primary care, Care Coordination, and Behavioral Health services covered under this Work are provided to Members within the established timely access to care standards. Contractor shall discourage Network Provider from placing Members on a wait list unless a Member consents. Contractor shall have processes and procedures established with Network Providers for warm hand-offs from the Provider to Contractor so Contractor can support Members in accessing care within the timeliness standards. Contractor shall work with Comprehensive Providers to support compliance with § 27- 50-302, C.R.S.

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

5.5.10.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed-upon performance target for SFY 2026-27 and 2027-28 regarding compliance with timely access to care standards. Beginning SFY 2028-29 Contractor shall achieve an aggregate 90% compliance with timely access to care standards as determined by an

independent secret shopper survey. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

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

5.5.11.1. Utilization of out-of-network Providers.

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

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

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

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

5.5.15. Network Changes and Deficiencies

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

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

5.5.15.1.2. Availability of covered services.

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

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

5.5.15.1.5. Strategy to provide status updates to the Department.

5.5.15.1.5.1. **DELIVERABLE**: Network Changes and Deficiencies Notice

5.5.15.1.5.2. **DUE**: Within five Business Days after Contractor's knowledge of the change or deficiency.

5.6. Network Adequacy Plan and Reports

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

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

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

5.6.1.3. Number of Network Providers by Provider type and areas of expertise as defined by the Department, that includes, but is not limited to:

5.6.1.3.1. Adult primary care Providers.

5.6.1.3.2. Pediatric primary care Providers.

5.6.1.3.3. Adult mental health Providers.

5.6.1.3.4. Pediatric mental health Providers.

5.6.1.3.5. SUD Providers.

5.6.1.3.6. Psychiatrists.

5.6.1.3.7. Child psychiatrists.

5.6.1.3.8. Psychiatric prescribers.

5.6.1.3.9. Family planning Providers.

5.6.1.4. Number of Network Providers accepting new Members by Provider type.

5.6.1.5. Geographic location of Providers in relationship to where Members live.

5.6.1.6. Cultural and language expertise of Providers.

5.6.1.7. Number of Providers offering after-hours and weekend appointment availability to Members.

5.6.1.8. Standards that will be used to determine the appropriate case load for Providers and how caseloads will be continually monitored and reported to the Department to ensure standards are being met and maintained across Contractor's Provider network.

5.6.1.9. Case load for Behavioral Health Providers.

5.6.1.10. Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough Providers are available to meet the needs in the region.

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

5.6.2. Contractor shall submit a Network Adequacy Report to the Department on a quarterly basis. The Network Adequacy Report shall contain, at a minimum, all of the following information:

5.6.2.1. Number and percent of PCMPs accepting new Members.

5.6.2.2. Number and percent of Behavioral Health Providers accepting new Members.

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

5.6.2.4. Number and percent of Behavioral Health Providers offering after-hours appointments.

5.6.2.5. Performance meeting timeliness standards.

5.6.2.6. Number of Behavioral Health Provider single-case agreements used.

5.6.2.7. New Providers contracted during the quarter.

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

5.6.2.9. Additional information, as requested by the Department.

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

5.6.3. Contractor shall deliver the Network Adequacy Report to the Department.

5.6.3.1. **DELIVERABLE**: Network Adequacy Report

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

5.6.4. Network Roster

5.6.4.1. Contractor shall submit to the Department a service Provider roster file in a format determined by the Department.

5.6.4.1.1. **DELIVERABLE**: Monthly Provider Roster

5.6.4.1.2. **DUE** Monthly, on the last Business Day of the month following the end of the previous month's reporting period

6. HEALTH NEIGHBORHOODS

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

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

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

6.2. Health Neighborhood(s)

6.2.1. Contractor shall support the successful engagement and utilization of the full range of Health Neighborhood Providers to help Members improve their health and life outcomes, this includes specialty care, Long Term Services and Supports (LTSS) Providers, hospitals, pharmacists, dental, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources Centers, and other ancillary Providers. In addition, the effective leveraging of the Health Neighborhood is a critical tool for controlling costs and wisely utilizing state resources.

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

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

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

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

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

6.2.2.5. Contractor shall identify, leverage, support, and complement existing performance networks operating within Contractor's assigned region to maximize impact and reduce duplication.

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

6.2.3.1. Contractor shall identify barriers to Provider participation in the Health Neighborhood, such as ineffective referral processes, high rates of Member no-shows, ineffective communication or other barriers.

6.2.3.1.1. Contractor shall implement programs to address the identified barriers to Provider participation in the Health Neighborhood and to support the efficient use of specialty care resources.

6.2.4. Contractor shall design and implement strategies to engage specialty care Providers that are critical to achieving the Department's cost and quality goals for the ACC, Value-Based Payment Models, and facility cost and quality indicator programs. Strategies shall include, but are not limited to:

6.2.4.1. Regularly scheduled outreach to specialty care Providers about Contractor and how the specialty care Provider can contact Contractor for assistance in coordinating services for Members.

6.2.4.2. Coordinating services to support Members' engagement in specialty care and reduce administrative burden for specialty care Providers. This may include services such as arranging NEMT, helping coordinate non-medical supports, addressing health-related social needs impacting the Member's condition, following up with Members that miss specialty care appointments, and ensuring the PCMP has shared appropriate clinical information and clinical questions.

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

6.2.4.4. Establishing contracted relationships with targeted specialty care Providers that include financial reimbursement for either ongoing work or for the specialty care Providers partnership in achieving incentive-based outcomes, such as KPIs orshared savings goals.

6.2.4.5. Providing support in implementing and utilizing telehealth solutions.

6.2.5. Contractor shall submit a Specialty Care Provider Engagement Strategy to the Department describing Contractor's plan to engage specialty care Providers in the ACC for the upcoming 12 months and a report on the outcomes of Contractor's activities during the previous 12 months.

6.2.5.1. **DELIVERABLE**: Specialty Care Provider Engagement Strategy

6.2.5.2. **DUE**: Annually, by December 31

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

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

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

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

6.2.6.2.1. Contractor shall actively endorse and direct referrals toward the highest-performing facilities as determined by the Department's indicators or other Department approved processes.

6.2.6.2.1.1. Contractor shall support PCMP adoption of available tools and cost and quality information to encourage PCMP referrals to higher preforming facilities and Providers in a way that improves health equity, closes disparities, and improves affordability within the Health First Colorado program.

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

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

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

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

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

6.2.10.1. Contractor shall support hospitals in achieving each hospital's chosen projects, interventions, and performance goals for the Hospital Transformation Program.

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

6.2.12. Contractor shall facilitate health data sharing among Providers in the Health Neighborhood.

6.2.13. Contractor shall establish relationships and communication channels with the entities administering the Department's NEMT benefit in order to ensure Members are able to attend Members' medical appointments on time. Contractor shall designate a single point of contact to lead Contractor's coordination of and collaboration with NEMT. Contractor shall share feedback with the Department on transportation challenges Contractor faces for Contractor's Members and other transportation issues of which Contractor becomes aware.

6.2.13.1. Contractor shall outreach and educate Members to call Contractor's Member call line for help arranging NEMT.

6.2.14. Given the importance of oral health to Members' health and life outcomes, Contractor shall establish relationships and communication channels with the Department's Dental Benefit managed care vendor to promote Member utilization of the dental benefits and identify network adequacy gaps to help the Department's Dental Benefit managed care vendor ensure comprehensive coverage and availability of dental services throughout the region.

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

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

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

6.2.15.3. Explore appropriate funding approaches to support collaborative activities.

6.2.16. Contractor shall partner with and align activities with advisory groups, performance networks, specialized programs, and statewide initiatives operating within Contractor's assigned region to strengthen the health care system and improve Member health. Contractor's partnerships shall include, but not be limited to, the following:

6.2.16.1. BHASOs, funded by BHA to provide Behavioral Health Services to vulnerable populations.

6.2.16.2. Colorado Crisis Care, Colorado's statewide resource within the Behavioral Health Administration for mental health, substance use, or emotional crisis help, information and referrals.

6.2.16.3. Colorado QuitLine, Colorado's statewide resource with information about tobacco cessation and free evidence-based tobacco cessation programs.

6.2.16.4. The Department's formal process for proposed benefit coverage policies, which establishes the amount, scope, and duration of Fee-For-Service benefits, ensures that covered services are evidence-based and guided by best practices, and develops collaborative working relationships with stakeholders.

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

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

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

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

6.2.16.7.1. Contractor shall establish a point of contact to communicate directly with the Utilization Management vendor.

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

6.2.16.7.3. Contractor shall work with the Utilization Management vendor regarding Members identified for the Department's COUP program as described in Section 13.6.2.

6.3. Health-Related Social Needs and Health and Social Equity

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

6.3.2. Recognizing that the conditions in which Members live also impact Members' health and well-being, Contractor shall establish relationships and work jointly with existing community organizations that provide resources such as food, nutrition supports, housing, transportation, interpersonal violence aid, energy assistance, childcare, education, social supports, and job training in the region.

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

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

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

6.3.4.1. Contractor shall not duplicate community efforts to create a directory. Instead, Contractor shall integrate, leverage, and participate in any existing state or regional efforts to build a regional resource directory, including, but not limited to, the Social Health Information Exchange (SHIE).

6.3.5. Contractor shall identify and promote Member referrals to and engagement with evidence-based and promising initiatives operating in the region that address health-related social needs, including both Community-Based Organizations and Network Providers engaged in this work.

6.3.6. Contractor shall engage with hospitals, the Colorado Department of Public Health and Environment, local public health agencies, Regional Health Connectors and Regional Health Alliances regarding existing community health needs and assessments to develop, implement and align collaborative strategies to reduce health inequities and disparities in the community. Strategies shall include attending hospitals' community health needs assessment meetings to ensure that the priorities of the Department, Members, and the Medicaid program are heard and incorporated into the community health assessments.

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

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

6.3.8. Health Equity

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

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

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

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

6.3.8.4. Contractor shall document and submit a Health Equity Plan to identify and address specific and targeted health disparities that impact Members within Contractor's assigned region. The plan shall include an inventory of current and future efforts around health

equity to reduce disparity rates and improve health outcomes among Colorado's historically underserved and marginalized communities.

6.3.8.4.1. Contractor shall document in the Health Equity Plan an inventory of current and future efforts around maternity and perinatal health, behavioral health and prevention, and centering health equity to improve health outcomes among Colorado's historically underserved and marginalized communities.

6.3.8.4.2. Contractor shall utilize the Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity Priorities in order to organize Contractor's plan, which must include, but is limited to:

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

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

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

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

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

6.3.8.4.3. Contractor shall review and update the Health Equity Plan at minimum, one time annually, by December 31. The Health Equity Plan shall document Contractor's achievements, successes, challenges, and plans for changes in Contractor's health equity strategy in a format determined by the Department.

6.3.8.4.3.1. Contractor shall submit the Health Equity Plan to the Department for review and approval.

6.3.8.4.3.1.1. **DELIVERABLE**: Health Equity Plan

6.3.8.4.3.1.2. **DUE**: Annually, by December 31

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

6.3.8.4.5. Contractor shall post Contractor's Health Equity Plan, including all updates and revisions, on Contractor's public facing website and provide ongoing updates on Contractor's progress on achieving Health Equity Plan goals, including performance metrics.

6.3.8.4.6. Contractor shall submit relevant Health Equity data to the Department at least two times per year regarding health equity performance in a format determined by the Department

6.3.8.4.6.1. **DELIVERABE**: Health Equity Data

6.3.8.4.6.2. **DUE**: At least twice per year, on a date determined by the Department

6.3.9. Targeted Health-Related Social Needs (HRSN)

6.3.9.1. Food Insecurity and Nutrition Support

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

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

6.3.9.1.3. Contractor shall participate in and align Contractor's activities with advisory groups, existing programs, and statewide initiatives to leverage resources and break down barriers to food access and nutrition supports.

6.3.9.1.4. Contractor shall provide training on nutrition assistance programs for Member-facing staff within the first six months of employment. This training can be conducted in partnership with a food advocacy organization in the state.

6.3.9.1.5. Contractor may establish partnerships with community organizations to support Member enrollment in the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

6.3.9.1.5.1. Contractor shall coordinate with and inform Contractor's assigned region State-contracted SNAP outreach and application organization and local county office regarding any planned Member outreach effort regarding food access.

6.3.9.1.6. Contractor shall educate Network Providers on the referral process for WIC, including the use of the online referral form and what information Members are required to provide for WIC eligibility consideration.

6.3.9.1.6.1. Contractor shall educate Network Providers to provide anthropometric data (e.g., height, weight, and hemoglobin) to Members to reduce barriers to Member enrollment in WIC.

6.3.9.2. Housing Insecurity

6.3.9.2.1. Services for the Homeless

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

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

6.3.9.2.1.2.1. Contractor shall establish relationships with regional Continuum of Care partners and report on those partnerships in the Health Neighborhood Report.

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

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

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

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

6.3.9.2.1.3.3. Coordinating the provision of supportive housing.

6.3.9.2.1.3.4. Coordinating housing-related services.

6.3.9.2.1.4. Contractor shall be a member of the regional Continuums of Care and participate in stakeholder meetings and case conferencing meetings, as necessary.

6.3.9.3. Permanent Supportive Housing (PSH)

6.3.9.3.1. Contractor shall maintain or partner with a network of PSH Providers in the region.

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

6.3.9.3.2. Contractor shall ensure the clinical services, particularly Behavioral Health services, are provided to Members who are qualified for and enrolled in PSH, especially during the period a Member is waiting to move into a permanent housing arrangement.

6.3.9.3.2.1. Contractor shall ensure Care Coordination services for Members qualified for PSH are documented and reported to the Department in the Health Neighborhood Report or through another mechanism as determined by the Department.

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

6.3.9.3.2.2.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed-upon performance target for the percentage of Members who are enrolled in PSH but are waiting to move into a permanent housing arrangement who received Care Coordination from Contractor or Contractor's delegated or Subcontracted entities during the previous quarter. Contractor shall not be held accountable for this Performance Standard prior to SFY 2026-27 or later as determined by the Department.

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

6.3.9.3.2.4. Contractor shall coordinate with PSH Providers who provide case management to ensure referrals occur when needed, specifically to physical and behavioral health services.

6.4. Health Neighborhood Report

6.4.1. Contractor shall submit a report, twice per Fiscal Year, to the Department describing Contractor's activities to collaborate with and build the Health Neighborhood to support

Members' health care and social needs, in addition to articulating plans for the Health Neighborhood in the Annual Contracted Network Management Strategic Plan.

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

6.4.2.1. **DELIVERABLE**: Health Neighborhood Report

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

7. POPULATION MANAGEMENT

7.1. Contractor shall utilize a population management approach to manage Contractor's overall Member population, identify and manage health and health-related social needs, address health disparities, and achieve better health outcomes while reducing unnecessary costs and services.

7.2. Contractor's population management approach shall align with the Department's goals and objectives and include, at a minimum, all of the following components:

7.2.1. Member engagement strategies.

7.2.2. Provider engagement and support.

7.2.3. A full range of clinical and non-clinical interventions.

7.2.4. Evidenced-based programs and promising practices designed to promote wellness, improve overall Member health, and prevent disease progression.

7.2.5. Comprehensive care coordination.

7.3. Contractor shall provide evidence based, industry standard condition management programming, including interactive Member technology solutions, that utilize an established curriculum or protocol designed to address common health conditions, including, but not limited to, Maternity, Diabetes, Hypertension, Asthma, and COPD.

7.3.1. Contractor shall develop programs to manage and support Members with specific health conditions when Contractor or the Department has identified gaps in care and programming to meet Member needs based on current data trends or claims information. Contractor shall prioritize health conditions for which its Network Providers do not have existing programs.

7.3.2. Contractor shall submit a Condition Management Report in a format determined by the Department. The Condition Management Report shall include data on Member engagement in Contractor's Condition Management programs.

7.3.2.1. **DELIVERABLE**: Condition Management Programming Report

7.3.2.2. **DUE**: February 14, 2026 and then every 6 months by August 15 and February 14.

7.4. Contractor shall describe Contractor's population management approach in a Population Management Strategic Plan in a format determined by the Department.

7.4.1. The Population Management Strategic Plan shall, at a minimum, describe all of the following:

7.4.1.1. Member engagement strategies.

7.4.1.2. The range of clinical and non-clinical interventions to be offered to Members and the correlating evidence-base, as appropriate.

7.4.1.3. Contractor's strategy to use predictive modeling analytics or software to target impactable populations.

7.4.1.4. Contractor's strategy for including Members, Network Providers, and Health Neighborhood providers and organizations as described in Section 6 in the development of the Population Management Strategic plan and supporting partners in the implementation of the overall population management approach.

7.4.1.5. Contractor's approach to monitor and assess the effectiveness of the population management approach, including the identification of population management specific metrics.

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

7.4.2.1.1. **DELIVERABLE**: Population Management Strategic Plan

7.4.2.1.2. **DUE**: Annually, by July 1

8. CARE COORDINATION

8.1. Overview

8.1.1. Contractor shall ensure whole person Care Coordination and Case Management (referred to collectively as Care Coordination) is available to and provided for Contractor's assigned Members using funds from both the Administrative Per-Member Per-Month payment and the Capitated Behavioral Health Benefit payment.

8.1.2. Contractor shall implement a comprehensive Care Coordination program that addresses the full range of Members' physical health, Behavioral Health, oral health, and health-related social needs as part of Contractor's overall population health management strategy.

8.1.3. Contractor's comprehensive Care Coordination program shall support the delivery of Care Coordination activities at the point of care and by those entities who have the strongest relationship with or most consistent engagement with a Member.

8.1.3.1. Contractor's comprehensive Care Coordination program shall include Care Coordination activities delivered by Contractor, Network Providers, and other state and community partners that may include CBOs and entities that are funded by other state agencies for related or complementary work.

8.1.3.2. Contractor shall be accountable for ensuring appropriate Care Coordination services are provided to Members regardless of who is providing Care Coordination.

8.1.4. Contractor shall develop and implement strategies and tools that provide the Department with information to understand and monitor how Members are receiving Care Coordination within Contractor's assigned region, whether provided by Contractor, Contractor's Network Providers, Subcontractors, or other delegated or contracted arrangements with regional partners.

8.1.5. Contractor's Care Coordination program shall have the goals of:

8.1.5.1. Preventing disease progression through interventions that target physical, behavioral, and oral health as well as health-related social needs.

8.1.5.2. Reducing unnecessary, avoidable, and duplicative Care Coordination, service utilization, and costs.

8.1.5.3. Improving coordination of care and reducing gaps in care across Medicaid programs and state benefits.

8.1.5.4. Improving Members' experience of care

8.2. Care Coordination Activities

8.2.1. Contractor shall work with the Department to standardize aspects of the delivery of Care Coordination within a three-tiered model that categorizes the types of Care Coordination services that should be made available for Members based on Member acuity and that identifies criteria for stratifying Members into each tier. Contractor shall implement the Care Coordination program in compliance with the Department approved and documented guidance regarding the Care Coordination three tier model.

8.2.1.1. During the Start-up Period, Contractor shall collaborate with the Department to modify the Department's three-tiered Care Coordination model, in advance of the Operational Start Date.

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

8.2.1.3. Contractor shall allow Contractor's clinical Care Coordination staff the discretion to move Members in and out of tiers based on clinical assessment of Members, organic referrals from entities serving Members directly, Member requests, and in line with Member needs and preferences, regardless of a Member's diagnosis.

8.2.2. Contractor's Care Coordination program shall consist of the following three tiers:

8.2.2.1. Tier 1 Care Navigation – for all Members, with an emphasis on prevention and wellness promotion and education: Contractor shall oversee the implementation of proactive and responsive education and benefit navigation that assists Members in accessing evidence-based preventive care services and navigating the Medicaid system.

8.2.2.2. Tier 2 Care Coordination – for Members with rising risk: Contractor shall oversee that interventions are in place (including but not limited to Condition Management programming) to prevent Members with rising risk from requiring higher levels of care.

8.2.2.3. Tier 3 Care Management – for Members with complex needs: For Members with multiple conditions, complex health and social needs, and high utilization, Contractor shall oversee that Members receive appropriate longitudinal evidence-based and proven programs that involve multi- disciplinary care approaches to maintain or improve Member health.

8.2.2.3.1. Contractor shall document in the Annual Population Management Strategic Plan how Contractor proposes to manage Care Coordinator to Member ratios for Members who have agreed to Care Coordination, including how ratios account for factors which may include, but are not limited to, Care Coordinator credentials/specialization, Member sub-populations, and whether or not caseloads are defined by tier or include a blend of tiers.

8.2.3. Care Coordination Activities

8.2.3.1. Contractor shall ensure that, at a minimum, the following Care Coordination activities are available to Members based on a Member's need:

8.2.3.1.1. Outreach and health promotion of evidence-based preventive care.

8.2.3.1.1.1. Contractor shall implement creative engagement strategies in collaboration with local partners, including CBOs, for Members who are not engaging in care.

8.2.3.1.1.2. Contractor shall promote a comprehensive or periodic oral evaluation at least one time annually for all Members.

8.2.3.1.1.2.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed-upon performance target that is not less than the previous three-year average on the dental visit engagement rate.

8.2.3.1.2. Screening for short- and long-term health needs using evidence-based tools, including for physical health, Behavioral Health, oral health, and Health Related Social Needs.

8.2.3.1.3. Referrals to resolve Members' identified needs, including follow up to ensure the closure of referral loops.

8.2.3.1.3.1. Contractor shall utilize the SHIE and related systems to improve coordination of services addressing Health Related Social Needs.

8.2.3.1.4. Documentation of care plans.

8.2.3.1.4.1. For Members in the Tier 3 Care Management, Contractor shall have policies and procedures to monitor and support whether comprehensive care plans are established within 90 days after Member consents to Care Coordination and updated at least twice a year for as long as the Member remains actively engaged in Tier 3 Care Management.

8.2.3.1.4.2. Contractor shall ensure comprehensive care plans for Members in Tier 3 Care Management contain, at minimum:

8.2.3.1.4.2.1. Measurable, time-bound, relevant Member-identified goals for whole-person care.

8.2.3.1.4.2.2. List of all entities and individuals involved in the Member's care, including identification of the lead care coordinator.

8.2.3.1.4.2.3. Agreed upon frequency of engagements with the Member and/or their care team.

8.2.3.1.4.2.4. The lead care coordinator may be a care coordinator/case manager from another entity that provides support around the Member's identified primary needs and serves as the Member's primary point of contact.

8.2.3.1.4.2.5. Member-specific criteria for successful discharge from Care Coordination.

8.2.3.1.4.3. In cases where another agency's care coordinator/case manager has been identified as the lead (e.g., High-Fidelity Wraparound or a CMA), Contractor shall follow and complement the goals of the other agency's care plan to avoid duplication.

8.2.3.1.4.3.1. Contractor shall document a copy or key elements of a lead agency's care plan in Contractor's care coordination platform for Members in Tier 3 Care Management.

8.2.3.1.4.3.2. **PERFORMANCE STANDARD**: Contractor shall ensure that a minimum of 25 care plans per 1000 assigned Members per year are created for Members eligible for Tier 3 Care Management.

8.2.3.1.5. Regular meetings between the Member and the Member's care team and/or care coordination team at appropriate intervals to meet the Member's goals and in accordance with established care/treatment plans.

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

8.2.3.1.5.2. For Members in Tier 3 Care Management, Contractor shall ensure Members have regular engagement, at a minimum of one time a month, with the Member's care coordinator and/or care team as agreed upon between Contractor and the Member or care team and documented in the care plan.

8.2.3.1.5.3. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed upon performance target for Members eligible for Tier 3 Care Management that received a Care Coordination engagement activity or care team visit per 1,000 assigned Members per year. Contractor shall not be held accountable for this Performance Standard prior to SFY 2026-27 or later as determined by the Department.

8.2.3.1.6. Coordination of care transitions for Members moving between levels of care.

8.2.3.1.7. Clinical case management for Members with complex health and social needs, including involvement with multiple agencies.

8.2.3.1.7.1. Contractor or its designated care coordinators shall participate in multi-Provider care teams and, as appropriate, multi-agency care teams for Members with co-occurring physical and/or Behavioral Health conditions and/or Members who receive services from various state agencies.

8.3. Care Coordination Approach

8.3.1. Contractor shall oversee that the full continuum of appropriate Care Coordination interventions is occurring for Members, whether delivered by Contractor, Network Providers, or by delegated or Subcontracted entities.

8.3.2. Contractor's Care Coordination program shall be administered utilizing the following characteristics:

8.3.2.1. Person and family-centered.

8.3.2.2. Trauma informed.

8.3.2.3. Accessible and inclusive.

8.3.2.4. Culturally Responsive.

8.3.2.5. Delivered at the point of care to the extent possible, leveraging Network Providers, Local Public Health Agencies, and CBOs.

8.3.2.6. Evidence-based.

8.3.2.7. Respectful of Member choice, including but not limited to:

8.3.2.7.1. Allows for Members to choose to replace their care coordinator, regardless of reason, barring extenuating circumstances.

8.3.2.7.2. Is delivered through multiple modalities as appropriate for a Member's needs and communication preferences (e.g., mobile, in-home, online, in community, telephonic).

8.3.2.8. Supports timely and consistent communication between the care coordinators, the Providers delivering services to Members, the Member, and the Member's care team.

8.3.3. Contractor shall utilize a continuum of para-professional and licensed clinical care coordinators (e.g., Registered Nurses, Social Workers, Community Health Workers, Navigators, and Clinical Leads) to appropriately address Members' unique needs.

8.3.3.1. Contractor shall ensure care coordinators have the appropriate level of knowledge of different systems and settings to serve specific populations and solve Care Coordination problems for those populations, 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.

8.3.3.2. Contractor shall ensure Care Coordination staff have knowledge of the Department's Fee-for-Service physical health benefits including, but not limited to, the Department's policies and associated rules for out-of-state care, NEMT, and in-home benefits such as private duty nursing, long-term home health, and personal care.

8.3.4. Contractor shall reduce duplication of efforts and overburdening Members and Providers by leveraging existing screenings, assessments, and care plans collected by other entities in the Health Neighborhood to the extent possible.

8.3.5. Contractor shall follow Department guidance for coordinating care for Members shared with other organizations/entities.

8.3.6. Contractor shall comply with Department requirements for coordinating care for Members identified for special initiatives, including but not limited to:

8.3.6.1. Children and youth eligible for the Child and Youth Medicaid System of Care.

8.3.6.2. Members eligible for services through any Department 1115 Waiver.

8.3.6.3. Members identified as At-Risk for Institutionalization and At-Risk Transition resulting from an agreement with the Department of Justice.

8.3.6.3.1. Contractor shall process a Department list of Members who are identified as At- Risk for Institutionalization and Diversion and outreach the identified Members within 10 Business Days of processing the Department list to provide, at a minimum, care transition support, information and referrals to community-based resources, and/or referrals to HCBS services.

8.3.6.4. Members who are transplant recipients with an SUD diagnosis.

8.3.6.4.1. Contractor shall follow the transplant patients with SUD Diagnosis protocol developed by the Department, including but not limited to making resources easily accessible on Contractor's website for hospital transplant teams to coordinate services.

8.3.7. Contractor shall comply with the Department's transition of care policy to ensure Member's continued access to services during a transition from one RAE to another RAE as required in 42 CFR § 438.62, including but not limited to a warm handoff initiated by the original care coordinator.

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

8.3.9. Care Coordination Subcontract/Delegation

8.3.9.1. Contractor may subcontract or delegate Care Coordination activities but shall be responsible for ensuring any subcontracted or delegated entity/Provider meets the appropriate Contract Performance Standards and Reporting Requirements.

8.3.9.1.1. Contractor's subcontracted or delegated arrangements may include organizations representing a network of Providers, PCMPs, or CBOs.

8.3.9.1.2. Contractor shall be responsible for monitoring organizations and Providers who have been subcontracted or delegated Care Coordination responsibilities.

8.3.9.1.3. Contractor shall provide any Care Coordination activities not offered by the delegated or subcontracted Care Coordination entity at no cost.

8.3.9.2. Contractor shall submit a comprehensive list of the subcontracted and delegated Care Coordination entities and Providers who are responsible for any Work involving delivery of Care Coordination for Members to the Department for review and approval.

8.3.9.2.1. Contractor shall define the relationship between Contractor and each subcontracted and delegated Care Coordination entity and Provider, including which is responsible for what forms of care coordination and for which Members.

8.3.9.2.1.1. **DELIVERABLE**: Care Coordination Roles Report

8.3.9.2.1.2. **DUE**: Annually, as part of the Annual Population Management Strategic Plan, and within 30 calendar Days after any change to a subcontracted or delegated relationship

8.4. Coordinating Care Transitions

8.4.1. Contractor shall develop and implement care transitions policies and procedures that expedite successful transitions and discharges by arranging and coordinating Medically Necessary on-going treatment and services addressing Members' health and health-related social needs while preventing unnecessary readmissions and/or ED visits, utilization of the wrong level of care, and other adverse health outcomes.

8.4.1.1. Contractor's policies and procedures shall incorporate evidence-based models and align with Department programs, including but not limited to the Hospital Transformation Program (HTP), Inpatient Hospital Transitions (IHT), and Creative/Complex Solutions.

8.4.1.2. Contractor's policies shall describe how it will manage care transitions from a broad array of services, including but not limited to physical and behavioral health hospitals, residential programs, EDs, 72-hour holds, nursing facilities, and crisis services supports.

8.4.1.3. Contractor shall have documented processes for handling discharges from out-of-state hospitals and residential programs.

8.4.2. Contractor shall have documented policies and procedures in place for Contractor and/or Network Providers to conduct care transition activities.

8.4.3. Contractor shall have processes to monitor that care transition best practice activities are being implemented by the discharging entity, the Member's care team, or other appropriate entities.

8.4.3.1. Contractor shall have processes to confirm Members have successfully engaged with services and supports as identified in the Member's discharge plan, as well as processes to follow up with the Member if they have not engaged.

8.4.3.2. Contractor shall ensure that care transitions provided by Contractor do not duplicate the efforts of the discharging/transitioning entity but should concentrate on implementing and monitoring the plan for the Member once they are ready for transition/discharge.

8.4.3.3. Contractor shall collaboratively establish policies and procedures, which could consist of a business associate agreement (BAA), memorandum of understanding (MOU), or Data Sharing Agreement, with physical and Behavioral Health hospitals, residential programs, nursing facilities, and crisis providers regarding care transition services that meet the unique needs and requirements of individual settings and systems and avoids duplication of services. The agreed upon policies and procedures shall address the following minimum information:

8.4.3.3.1. Communication and data sharing procedures, including but not limited to a process to identify Members ready to transition.

8.4.3.3.2. Defined roles and responsibilities for Member discharge/transition planning, including timeframes as appropriate.

8.4.4. Contractor shall review relevant data feeds every Business Day to prioritize care transition support, including but not limited to:

8.4.4.1. ADT data from all Colorado Health Information Exchange platforms.

8.4.4.2. IHT feeds.

8.4.5. Contractor shall document in Contractor's Care Coordination platform and/or obtain from the discharging/transitioning entity the discharge plan, crisis follow-up plan, safety plan, IHT documentation, and other relevant care plans or documentation.

8.4.6. Contractor shall ensure care transitions within Contractor's assigned region follows best practices that include, at minimum, all of the following:

8.4.6.1. Initiation of collaboration with the hospital, residential program, or crisis supports, and the Member and/or the Member's caregivers, as soon as possible to prepare for successful transition.

8.4.6.2. Notification of the Member's care team of an admission/encounter.

8.4.6.3. Outreach to the Member and/or the Member's caregiver within two Business Days following notification to Contractor of discharge/transition to:

8.4.6.3.1. Ensure a follow up appointment with a licensed health care Provider has been scheduled following discharge/transition within the following parameters:

8.4.6.3.1.1. 30 days for physical health, especially when discharged from a hospital.

8.4.6.3.1.2. Seven days for Behavioral Health, especially when discharged from a hospital.

8.4.6.3.2. Support the Member with scheduling a follow-up appointment with a licensed health care Provider if no appointment exists.

8.4.6.3.3. Coordinate support and resources, including but not limited to transportation, so that Member can attend the Member's follow up appointment.

8.4.6.3.4. Complete medication review or confirm completion of medication review, if applicable to Member's care plan. Contractor shall facilitate warm hand-off to Member's care team if there are questions regarding medication.

8.4.6.4. Obtain a copy of the Member's discharge plan, and in the case of a Behavioral Health discharge/transition, a copy of the Member's crisis plan, or discuss a Member's discharge plan with the entity overseeing a Member's discharge to identify any actions Contractor may need to take to assist with a successful transition. Contractor shall document the reason when a discharge plan was not made available to Contractor or Contractor was unable to discuss the discharge plan with the entity overseeing a Member's discharge in order to identify and address systemic issues that may be contributing to unsuccessful care transitions.

8.4.6.5. Notification of the Member's care team of the Member's discharge/transition.

8.4.7. Upon Department request, Contractor shall make available adequate and appropriately trained clinical Care Coordination staff (e.g., nurses or physicians) with experience in addressing a Member's needs.

8.4.8. Contractor shall actively work with ED, residential, and inpatient facilities to facilitate timely Member discharge.

8.4.9. Contractor shall work with the Department, BHA, and other relevant state agencies to review cases of Members that have been indicated as posing difficulties for returning back to the community and develop an agreed-upon transition plan. Contractor shall identify barriers to discharge and develop an appropriate transition plan back to the community.

8.4.9.1. Contractor shall regularly report on Members experiencing challenges to discharge from hospitals, in a format determined by Department.

8.4.9.1.1. **DELIVERABLE**: Weekly Hospital Discharge Status Report

8.4.9.1.2. **DUE**: Weekly, on a day of the week determined by Department

8.4.9.1.3. Contractor shall submit IHT Reports to the Department quarterly using a Department template.

8.4.9.1.3.1. **DELIVERABLE**: IHT Report

8.4.9.1.3.2. **DUE**: Quarterly, as determined by the Department

8.4.10. ED Utilization and Readmissions

8.4.10.1. Contractor shall have a documented plan to identify Members who are overutilizing the ED or experiencing multiple readmissions for both physical health and behavioral health needs and shall employ outreach strategies to determine the cause. Contractor shall offer education and other appropriate interventions to Members to reduce inappropriate ED utilizations or unnecessary readmissions.

8.4.10.2. Contactor's plan for physical health shall include, but is not limited to:

8.4.10.2.1. Measurable strategies to reduce 30-day, 90-day, and 180-day repeat ED visits and hospital readmission rates attributed to physical health concerns.

8.4.10.2.2. Contractor's approach to ensuring Members experiencing readmissions or repeated ED utilization are receiving Care Coordination that, at a minimum, assists Member access to recommended outpatient treatments and medications to support the Member's progress on achieving the Member's physical health goals.

8.4.10.2.3. Policies for reviewing Member specific data with the Member's Providers, which may include the Member's PCMP and other Condition Management Programs, as applicable.

8.4.10.2.4. Contractor's plan for behavioral health shall include, but is not limited to:

8.4.10.2.4.1. Measurable strategies to reduce 30-day, 90-day, and 180-day readmission rates in residential and inpatient treatment settings for mental health and SUD.

8.4.10.2.4.2. Strategy for monitoring the 30-day, 90-day, and 180-day readmission rates to:

8.4.10.2.4.2.1. Colorado's Mental Health Hospitals.

8.4.10.2.4.2.2. Freestanding Psychiatric Hospitals.

8.4.10.2.4.2.3. PRTFs.

8.4.10.2.4.2.4. QRTPs.

8.4.10.2.4.2.5. Residential and inpatient treatment Providers of SUD.

8.4.10.2.4.3. Measurable strategies to reduce repeated ED utilization rates attributed to mental illness and SUD.

8.4.10.2.5. Contractor's approach to exhausting all reasonable efforts to ensure Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Covered Services after discharge from residential, inpatient, or ED care due to a Behavioral Health reason, with sufficient frequency and amounts to support the Member's progress on achieving the Member's Behavioral Health goals.

8.4.10.2.6. Policies for reviewing Member specific data with the Member's Providers, which may include the Member's PCMP and other Mental Health or SUD Treatment Programs, as applicable.

8.4.11. Colorado Mental Health Hospitals and Freestanding Psychiatric Hospital Transitions

8.4.11.1. Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Colorado mental health hospitals and Freestanding Psychiatric Hospitals to safe and alternative environments.

8.4.11.2. Contractor shall participate in discussions and Care Coordination with the Colorado Mental Health Hospitals and Freestanding Psychiatric Hospitals.

8.4.11.3. Contractor shall work with the Colorado Mental Health Hospitals to execute communication and transition plans for Members.

8.4.11.4. Contractor shall designate a liaison to assist in facilitating a coordinated discharge planning process for Members admitted to Colorado Mental Health Hospitals or private Freestanding Psychiatric Hospitals.

8.4.11.4.1. Contractor's liaison shall assist and collaborate with the applicable Network Provider to expedite discharge and engagement in ongoing Covered Services.

8.4.11.4.2. Contractor shall actively assist the Colorado mental health hospitals and private Freestanding Psychiatric Hospitals treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable state and federal regulations.

8.4.11.4.3. Contractor shall actively participate with and assist Colorado mental health hospitals and other private Freestanding Psychiatric Hospitals staff in the development of a written discharge plan within one Business Day after a Member's admission.

8.4.11.4.4. Contractor shall ensure Members are scheduled for an appointment with an appropriate mental health clinician and that transportation has been arranged for the appointment prior to discharging a Member. Such appointment shall occur within seven calendar days after a Member's discharge.

8.4.11.4.4.1. Contractor shall have policies and procedures to exhaust all reasonable efforts to ensure that Members receiving Assertive Community Treatment (ACT) team services are seen by the applicable Provider within one Business Day after the Member's discharge.

8.4.11.4.5. Contractor shall implement policies and procedures to support the provision of the discharge progress note to the aftercare Provider prior to a Member's discharge.

8.4.11.4.5.1. For ACT team service recipients, Contractor shall have policies and procedures to support the Colorado mental health hospitals and other private Freestanding Psychiatric Hospitals in providing the discharge progress note to the ACT Provider, within 24 hours after a Member's discharge.

8.4.11.4.6. Contractor shall ensure Members have been outreached within 72 hours after the Member's discharge from Colorado Mental Health Hospitals, Freestanding Psychiatric Hospitals, or other facility identified as an IMD in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

8.4.11.4.6.1. **PERFORMANCE STANDARD**: Contractor shall ensure that 95% of Members discharged from Colorado Mental Health Hospitals, Freestanding Psychiatric

Hospitals, or other facility identified as an IMD have been outreached within 72 hours after the Member's discharge.

8.4.12. Crisis System Transitions

8.4.12.1. Contractor shall collaborate with the BHASOs and Colorado Crisis System, including but not limited to Mobile Crisis Response Provider(s), in Contractor's assigned region to facilitate timely notification of Contractor, timely follow-up outreach, and timely treatment for enrolled Members who have accessed crisis services.

8.4.12.2. Contractor shall have documented processes in place to identify and support Members who frequently make contact with crisis system providers.

8.4.12.3. Contractor shall require mobile crisis response Providers outreach Members within five calendar days after onset of a Member's crisis episode in order to support the Member in attending any scheduled follow-up appointments.

8.4.12.3.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed upon performance target for Members who have had contact with a mobile crisis response Provider that have been outreached within five days of the Member's initial contact with the mobile crisis response provider. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

8.5. Collaborations for Coordinating Care for Shared Members

8.5.1. Contractor shall establish documented policies and procedures to facilitate effective collaboration, communication, and coordination with state and county agencies and programs, providers, health plans, and community organizations serving shared Members.

8.5.2. Contractor's collaborative arrangements may be documented informally or through formal vehicles such as a BAA, MOU, data sharing agreement, or Subcontracting relationship.

8.5.2.1. Contractor's collaborative arrangements shall address, but not be limited to, the following:

8.5.2.1.1. A brief definition/overview of the collaborative work responsibilities.

8.5.2.1.2. Standards, processes, and workflows for cross-agency communication and coordination in various areas, which may include, but is not limited to regular meetings, training, Member outreach, Member referrals, case consultations, and transitions of care, as appropriate.

8.5.2.1.3. Roles and responsibilities, including which program will take on the role as lead care coordinator.

8.5.2.1.4. Data sharing, whenever possible and appropriate, and analysis protocols.

8.5.2.1.5. A process for escalating concerns when necessary.

8.5.3. Contractor may offer collaborating organizations access to Contractor's Care Coordination platform, as deemed appropriate, and develop a data sharing agreement with the entity to ensure Contractor is able to report on required Care Coordination metrics, including a Member's bi-directional engagement in Care Coordination.

8.5.4. Community Based Organizations (CBOs)

8.5.4.1. Contractor shall strengthen and support a network of local CBOs in order to identify and engage with Members who are unreachable through conventional methods (e.g., phone, text, mail) and/or Members who underutilize preventive care, case management, and condition support programs in an effort to improve equitable access to care, quality outcomes, and affordability.

8.5.4.2. Contractor shall identify appropriate CBOs in Contractor's assigned region that may include, but are not limited to food banks, shelters, community centers, and agencies supporting marginalized Members (such as covered immigrants, refugees, indigenous peoples, individuals experiencing homelessness, etc.).

8.5.4.3. Contractor shall prioritize CBOs that employ Community Health Workers who are registered through the Department of Public Health and the Environment but that are ineligible for Medicaid FFS reimbursement.

8.5.4.4. Contractor may provide financial support to CBOs for conducting outreach, health promotion, and Care Coordination for Contractor's Members.

8.5.4.5. Contractor may co-locate Contractor's own care coordinators or train existing CBO staff to conduct Care Coordination activities with support and guidance from Contractor, especially for Members who face health inequities and those Members who would benefit from support in Tier 2 Care Coordination or Tier 3 Care Management.

8.5.4.6. Contractor shall leverage existing environmental scans, the Department's and Contractor's Health Equity Plan, and data collected by other state agencies to determine which locations and populations to focus on within Contractor's assigned region.

8.5.4.7. Contractor shall track the number of referrals to Care Coordination generated through Contractor's CBO network and as requested by the Department, deliver a Care Coordination report on a template provided by the Department.

8.5.4.7.1. **DELIVERABLE**: CBO Care Coordination Report

8.5.4.7.2. **DUE**: As requested by the Department

8.5.5. Case Management Agencies (CMAs)

8.5.5.1. Contractor shall establish and maintain strong and ongoing relationships with all CMAs serving shared Members in accordance with guidance provided by the Department. Contractor shall collaborate with the Department and CMAs to review and update this guidance at least one time annually.

8.5.5.2. Contractor shall establish a dedicated email address and phone line for CMAs in Contractor's assigned region to submit information, questions, share updates, etc.

8.5.5.3. Contractor shall respond to CMAs in a timely manner, meaning no longer than two Business Days, to ensure Members needs are addressed.

8.5.5.4. Contractor shall set regularly occurring meetings with its CMA partners that include but are not limited to:

8.5.5.4.1. Monthly check-ins or huddles.

8.5.5.4.2. Regular caseload reviews.

8.5.5.5. Contractor shall utilize the Department's care and case management tool utilized by the CMAs to monitor Member activities to the extent possible.

8.5.5.6. Contractor shall have documented processes for performance improvement regarding Contractor's collaboration with CMAs to monitor and implement necessary improvements.

8.5.5.7. Contractor shall participate in Department-led activities to improve oversight and monitoring. These activities may include, at minimum, the following:

8.5.5.7.1. Regularly participating in the CMA-RAE Cross Agency Forum.

8.5.5.7.2. Creating and participating in cross-functional group meetings to review data and Deliverables.

8.5.5.7.3. Modifying surveys and tools to capture HCBS population specific information and data.

8.5.5.8. Contractor shall work with the Department and CMA partners to identify, create, participate in, and administer training necessary to provide seamless Care Coordination to shared Members.

8.5.5.9. Contractor shall work with the Department and CMA partners to report on and improve Member and caregiver experience in a format agreed upon by Contractor and Department.

8.5.6. Dual Eligible Special Needs Plans (D-SNPs)

8.5.6.1. Contractor shall collaborate with the Department and D-SNPs to improve the effective management and coordination of care for dually-enrolled Medicare and Medicaid Members over the term of the Contract. The Department may revise contract requirements to conform with CMS guidance and regulations regarding D- SNPs, with which Contractor shall comply.

8.5.6.1.1. Contractor shall enter into documented agreements in accordance with requirements of 8.5.2 with each D-SNP in Contractor's assigned region and any other D-SNP known to be serving Contractor's Members to ensure dually-enrolled Medicare and Medicaid Members receive the most effective and comprehensive care.

8.5.6.2. Contractor shall collaborate with D-SNPs responsible for shared Members to conduct a comprehensive analysis of the benefit structure between D-SNP plans and the Medicaid benefits to ensure a thorough comprehension and application in coordinating Medicaid services for Members and jointly educate Providers that serve dually-enrolled Members to improve Provider utilization of available benefits and patient outcomes.

8.5.6.3. Contractor shall actively collaborate with the D-SNP to complement and support the D-SNP's Care Coordination activities, particularly as the activities relate to Medicaid services not covered by the D-SNP.

8.5.6.4. Contractor shall identify D-SNP enrolled Members on ADT feeds and have processes to identify and coordinate appropriate Care Coordination services to optimize a Member's outcomes and reduce duplication of efforts.

8.5.6.4.1. Contractor shall establish a robust system to receive and manage Skilled Nursing Facility (SNF) and inpatient admission information provided by the D-SNP within two Business Days of a Member's admission.

8.5.6.4.2. Contractor shall continuously monitor SNF and inpatient admissions to ensure that timely and appropriate responses are made, including, at minimum, necessary Care Coordination activities that contribute to the successful inpatient outcomes.

8.5.6.5. Contractor shall have documented policies and procedures developed with the D-SNPs responsible for shared Members for timely collaboration to address the Care Coordination needs of shared Members that are stratified in Tier 3 Care Management, aiming to improve health outcomes for these Members. Contractor shall report these procedures as part of the Policy and Procedures Deliverable

8.5.6.6. Contractor shall track and ensure care coordination engagement rates and appropriate types of Care Coordination are being provided to the D-SNP Members. Contractor shall utilize the data collected to improve care outcomes and Care Coordination efforts.

8.5.7. BHASOs

8.5.7.1. Contractor shall develop a workflow with the BHASO in Contractor's assigned region in order to notify one another when a Member is actively engaged in Care Coordination and will be transitioning from one entity to the other because of a change in Medicaid enrollment status.

8.5.7.1.1. Contractor shall make every effort to ensure Members returning to the RAE from a BHASO are re-assigned to the same care coordinator, as appropriate.

8.5.7.2. For former BHASO Members newly enrolled in Medicaid, Contractor shall facilitate a smooth transition by ensuring an assigned care coordinator conducts the following activities:

8.5.7.2.1. Offers continued Care Coordination at least at the same level as provided under the BHASO while Contractor works to engage the Member and update the Member's care plan.

8.5.7.2.2. Collects documentation that will aid in supporting the Member's Care Coordination goals, including but not limited to assessments, care plans, and/or crisis plans, as available.

8.5.7.3. If a Member is being disenrolled from Medicaid and has continued Behavioral Health needs, Contractor shall ensure the care coordinator conducts the following activities:

8.5.7.3.1. Connects the Member to the appropriate BHASO and follows up to ensure contact has been made.

8.5.7.3.2. Provides the BHASO care coordinator with documentation that will support the Member's continued Care Coordination needs are met, including but not limited to assessments, care plans, and/or crisis plans.

8.5.8. Child Welfare/Foster Care

8.5.8.1. Contractor shall work with each county child welfare office in Contractor's assigned region in order to improve the timely notification of children and youth Members involved in the child welfare system who require Care Coordination support, including but not limited to Members in foster care and those who have recently (within one year) emancipated from foster care.

8.5.8.2. Contractor shall address the complex health risks for children and youth in foster care by monitoring and coordinating a child or youth's utilization of consistent, preventative care in medical, behavioral, vision, and oral health.

8.5.8.3. Contractor shall engage children and youth in the Child and Youth Medicaid System of Care as determined eligible in accordance with Section 11.

8.5.8.4. Contractor shall implement evidence-based and promising practices to support the transition of emancipated foster care youth (at least six months prior to emancipation and at least one year post emancipation) that complement the work of child welfare and other state programs supporting this population.

8.5.8.4.1. Contractor shall ensure that the care plan for each emancipated foster care youth is informed by an assessment of the young person's transition readiness.

8.5.8.4.2. Contractor shall offer transition education to young people preparing to emancipate, including but not limited to education about continuing prescribed medications, attending physical and Behavioral Health appointments, receiving preventative care, independent living skills, etc.

8.5.8.4.3. Contractor shall support the young person's engagement with existing programs serving youth transitioning out of foster care, including the John H. Chafee Foster Care Program for Successful Transition to Adulthood.

8.5.9. Justice-Involved Members

8.5.9.1. Contractor shall participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for Members involved in carceral settings.

8.5.9.2. Contractor shall partner with the Department and the Colorado Department of Corrections (CDOC), Division of Youth Services, Colorado Judicial Branch, and jails in Contractor's assigned region to identify and provide services to Medicaid- eligible individuals being released from carceral settings to enable the Medicaid-eligible individuals to transition successfully to the community.

8.5.9.3. Contractor shall receive and process a list from the CDOC containing information about incarcerated individuals who have recently been released or will be released in the near future.

8.5.9.3.1. Contractor shall process the lists to identify individuals who are assigned to Contractor or will be released to Contractor's assigned region and are likely to be assigned to Contractor.

8.5.9.4. Contractor shall provide services to Members assigned to or who are likely to be assigned to Contractor that include, but are not limited to:

8.5.9.4.1. Timely outreach and transitional support to assist a Member's successful transition to the community.

8.5.9.4.2. Activities prior to a Member's release in accordance with any federally approved waiver agreement or federal requirement, including but not limited to an assessment to identify needs the Member will have upon release.

8.5.9.4.3. Care transition support, which may include but is not limited to supporting continued access to all medications prescribed to the Member during and/or prior to incarceration, including but not limited to Medication Assisted Treatment.

8.5.9.4.4. Coordination of transitional support between CDOC, Division of Youth Services, jails, and other RAEs for Members who were likely to but ultimately were not assigned to Contractor.

8.5.9.4.5. Contractor shall connect Members deemed incompetent to proceed with appropriate restoration services whether or not the services are covered by Medicaid, in coordination with the Office of Civil and Forensic Mental Health.

8.5.10. Creative Solutions/Complex Solutions Expectations

8.5.10.1. Contractor shall lead and facilitate Complex Solutions meetings for adults and Creative Solutions meetings for children in accordance with Department policies.

8.5.10.2. Contractor shall ensure that Creative Solutions and Complex Solutions meetings include the Member's care team, the member's Case Management Agency, and Department staff in order to identify solutions for Members experiencing significant barriers to care, including but not limited to difficult placements.

8.5.10.3. Contractor shall use templates provided by the Department to refer, track, and monitor Members involved in Creative/Complex Solutions, including, at minimum, documenting the following information:

8.5.10.3.1. Contractor's demonstrated efforts and attempts to identify Member solutions prior to referring to Creative/Complex Solutions.

8.5.10.3.2. A plan to bridge support for Members between discharge from higher levels of care and waitlists for step-down services.

8.5.10.3.3. When solutions are unsuccessful, summarize the reasons and any missed opportunities and/or future plans to prevent similar outcomes.

8.5.10.3.3.1. **DELIVERABLE**: Creative/Complex Solutions Report

8.5.10.3.3.2. **DUE**: To be determined by the Department

8.6. Care Coordination Policy Guide

8.6.1. Contractor shall have documented policies and procedures for the delivery of Care Coordination in Contractor's assigned region in accordance with the Work.

8.6.1.1. Contractor's documented Care Coordination policies and procedures shall:

8.6.1.1.1. Differentiate the strategies used for children from those used for adults by each tier.

8.6.1.1.2. Include descriptions of the specific interventions that Contractor or its Network Providers, delegated or subcontracted entities will employ, the identified populations of focus, the criteria for deploying the interventions, and how Contractor will measure the effectiveness in alignment with Department guidelines.

8.6.1.1.2.1. Contractor shall specify how it will collaborate with Network Providers and subcontracted or delegated entities to provide Care Coordination activities the other parties are unable to offer to ensure every Member receives equal access to the full continuum of Care Coordination.

8.6.1.1.3. Describe specific strategies for identifying, engaging, and coordinating care for populations meeting Department criteria for Care Coordination as well as demographic populations historically subject to health inequities.

8.6.1.1.4. Document policies and procedures for care transitions as detailed in Section 8.4.

8.6.1.1.5. Document policies and procedures for system collaboration, including but not limited to collaboration with CBOs, D-SNPs, CMAs, BHASOs, the child welfare system, and justice-involved Members.

8.6.2. Contractor shall submit Care Coordination policies and procedures to the Department prior to the Operational Start Date and upon Department request.

8.6.2.1. **DELIVERABLE**: Care Coordination Policies/Procedures

8.6.2.2. **DUE**: June 1, 2025, with updates due upon Department request

8.7. Data, Systems, & Performance

8.7.1. Contractor shall provide Care Coordination tools, processes, and methods to Network Providers for their utilization.

8.7.2. Contractor shall ensure that clinical and claims data feeds, including but not limited to ADT data received from a Colorado Health Information Exchange, monthly claims data, CMA case manager data feeds, the Inpatient Hospital Transitions data feed, and the Nurse Advice Line Data feed, are actively used in providing Care Coordination for Members.

8.7.3. Contractor shall receive, process, and analyze clinical, claims, and other available data from the State and Contractor and shall work collaboratively with the Department to stratify Contractor's population into the Care Coordination tiers, as well as identify trends, potentially avoidable costs, and impactable populations.

8.7.4. Contractor shall facilitate data sharing across all treating Providers, Subcontractors, and delegated entities, and ensure the completion of necessary consents and releases of information.

8.7.5. Contractor shall collect minimum data across all organizations and care coordinators to whom Contractor contractually delegates Care Coordination. Member engagement in Care Coordination shall be defined as bi-directional communication where the Member response is more than the Member opting out of Care Coordination. Communication can occur in-person or through telecommunication including phone, text, email, video, or Member portal.

8.7.6. Contractor shall develop and maintain mechanisms to collect the Care Coordination engagement information from Subcontractors, delegated Care Coordination entities, and Network Providers performing Care Coordination as part of Contractor's established payment arrangement with Contractor's Subcontractors, delegated Care Coordination entities, and Network Providers performing Care Coordination.

8.7.6.1. Contractor shall be responsible for cleaning and collating the data for submission to the Department.

8.7.7. Contractor shall submit Care Coordination Engagement Data to the Department in a standardized format determined by the Department.

8.7.7.1. Contractor shall submit, at a minimum, all of the following Care Coordination engagement data:

8.7.7.1.1. Member identifier for Members who actively engaged in a Care Coordination intervention during the previous month.

8.7.7.1.2. Member's Care Coordination stratification tier based on Contractor's methodology.

8.7.7.1.3. Entity who provided the Care Coordination intervention.

8.7.7.1.4. Date of Care Coordination intervention.

8.7.7.1.5. Member identifier for Member's who opted out of Care Coordination.

8.7.7.1.6. Member has a documented comprehensive care plan: yes/no.

8.7.7.1.6.1. **DELIVERABLE**: Care Coordination Engagement Data

8.7.7.1.6.2. **DUE**: Quarterly, not later than October 15, January 15, April 15, and July 15

8.8. Care Coordination Outcome Metrics

8.8.1. Contractor's Care Coordination program shall be evaluated based on Contractor's performance on the following metrics:

8.8.1.1. Care coordination outreach engagement: Contractor shall report the number of outreach attempts for Members in Contractor's Tier 3 Care Management.

8.8.1.2. Hospital All-cause Readmission rate based on NCQA methodology

8.8.1.2.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed upon performance target that shall not be more than the previous three year average for the Hospital All-Cause Readmission rate for Members in Tier 3 Care Management.

8.8.1.3. Transitions of care from hospitals for physical health conditions (based on HEDIS methodology): The percent of Members who received a follow-up service within 30 days after discharge during the previous quarter.

8.8.1.3.1. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed upon performance target for Members who have had an ED visit or inpatient (IP) admission that have been outreached or received a follow-up visit within seven Business Days of the ED or IP encounter per year. Contractor shall not be held accountable for this Performance Standard prior to SFY 2026-27 or later as determined by the Department.

8.8.1.4. Transitions of care from Behavioral Health inpatient stay (based on HEDIS methodology): The percent of Members who received a follow-up service within seven days after discharge during the previous quarter.

8.8.1.5. Ambulatory Care: ED Visits based on NCQA methodology.

8.8.1.5.1. **PERFORMANCE STANDARD**: The Department and MCEs shall mutually agree upon a performance target and methodology for annual performance improvement for the ED Visit performance metric for Members eligible for Tier 2 Care Coordination and Tier 3 Care Management

8.8.2. Contractor shall submit a Care Coordination Report to the Department in a format determined by the Department. The report shall include an overview of the Care Coordination activities for Members performed by Contractor, Network Providers and Partners, and Subcontractors.

8.8.2.1. **DELIVERABLE**: Care Coordination Report

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

9. PROVIDER SUPPORT AND PRACTICE TRANSFORMATION

9.1. Overview

9.1.1. Contractor shall serve as a central point of contact for Network Providers regarding Medicaid services and programs, Department Value Based Payment strategies and programs, regional resources, clinical tools, integrated care, and general administrative information.

9.1.2. Contractor shall serve as a vital support to the success and sustainability of primary care and the continuum of Behavioral Health throughout Contractor's region by providing data, actionable analytics, education, and supplemental services and supports to make it easier for Network Providers to deliver care to Members and by reducing administrative burdens and barriers where possible.

9.1.2.1. Taking into consideration alignment with other RAE and Department efforts, Contractor shall identify and work to reduce administrative burdens and barriers for Network Providers where possible and engage the Department as necessary around statewide issues and challenges Network Providers face across the RAE regions.

9.1.3. Contractor shall use Contractor's Population Health Management Strategy defined in Section 7 to inform Contractor's Practice Support activities for Network Providers.

9.1.4. Contractor shall offer Network Providers the following types of support, described in further detail in the rest of this section:

9.1.4.1. Provider communications.

9.1.4.2. General information and administrative support.

9.1.4.3. Provider training.

9.1.4.4. Data systems and technology support.

9.1.4.5. Practice transformation, financial support, and reporting.

9.1.5. Contractor shall submit an Annual Contracted Network Management Strategic Plan that includes, at minimum all of the following information:

9.1.5.1. Contractor's Network Adequacy Plan.

9.1.5.2. The types of information and administrative support, Provider trainings, and data and technology support Contractor shall offer and make available to Network Providers.

9.1.5.3. The practice support and practice transformation activities Contractor will implement to support successful Network Provider participation in Department efforts to integrate behavioral and physical health care delivery, to incorporate community health workers into the Medicaid delivery system, to implement Value-Based Payment models, and to achieve Department quality and cost savings targets.

9.1.5.4. The practice transformation strategies Contractor will offer to help practices progress along CDOI's defined aligned core competencies for primary care alternative payment models as well as strategies to help practices engage with Contractor's efforts to implement Contractor's Population Management Strategy.

9.1.5.5. How Contractor is supporting Network Providers and the region with improving coordination throughout the Health Neighborhood and reducing costs. Details could include practice support, utilization of Department dashboards and data, performance data, and more.

9.1.5.6. Descriptions of Contractor's work, including successes and lessons learned, during the previous year.

9.1.5.7. Savings and engagement performance of each PCMP, for each delegated obligation or program.

9.1.5.8. Comparison between Contractor's engagement and savings versus delegated PCMP engagement and savings.

9.1.5.9. Reporting of barriers and burdens Network Providers face, the strategies Contractor pursued to help ease identified barriers and burdens, and identification of issues that may require Department and or State intervention.

9.1.5.10. Contractor shall submit the Annual Contracted Network Management Strategic Plan to the Department.

9.1.5.10.1. **DELIVERABLE**: Annual Contracted Network Management Strategic Plan

9.1.5.10.2. **DUE**: Annually, by August 1

9.1.5.10.3. Contractor shall submit a Practice Support and Transformation Report to the Department that provides updates on Contractor's implementation of Provider support and practice transformation activities described in the Annual Contracted Network Management Strategic Plan. Contractor shall document, at a minimum, progress on milestones and outcome goals, notable barriers and burdens Network Providers are facing, and lessons learned.

9.1.5.10.4. **DELIVERABLE**: Practice Support and Transformation Report

9.1.5.10.5. **DUE**: Annually, by February 1

9.2. Provider Communication

9.2.1. Contractor shall have documented policies and procedures to confirm that Contractor's Provider communications adhere to the Department's brand standards.

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

9.2.3. Contractor shall maintain, staff, and publish the number for a toll-free telephone line, a general Provider relations email address, and a web-based form that Providers may contact regarding general information, administrative support, and complaints, including but not limited to, all of the following: contracting, credentialing, claims, and payment.

9.2.3.1. Contractor shall post their relevant Provider relations email address, phone number, and web-based form on their website.

9.2.3.2. During Business Hours, Contractor shall have processes and procedures to prevent more than five percent of phone calls being abandoned in any consecutive 30 day period. A call shall be considered abandoned if the caller hangs up after that caller has waited in the call queue for 180 seconds or longer.

9.2.3.3. Contractor shall have processes and procedures to ensure that the average length of time phone callers wait in the call queue before the call is answered shall be two minutes or less during each calendar month.

9.2.3.4. Contractor shall have no more than five phone calls during any consecutive five Business Days that experience a maximum delay of ten minutes or longer, and no calls shall exceed a maximum delay over 20 minutes.

9.2.3.4.1. **PERFORMANCE STANDARD**: 98% compliance with each Provider call line contract management requirement each month.

9.2.3.5. Contractor shall respond to all Provider inquiries within two Business Days.

9.2.3.6. Contractor shall have an automated response to their Provider relations email and/or web-based form that states the expected response time and provides a link to the Department Provider Escalation Request Form.

9.2.3.7. Contractor shall submit monthly response time data from its Provider telephone line, Provider relations email, and web-based form in the Call Line Statistics Report.

9.2.4. Contractor shall collaborate with the Department to respond to and address complaints submitted to the Department through the Department Provider Escalation Request Form or other mechanisms.

9.2.4.1. Contractor shall outreach Providers who have submitted a complaint to the Department within two Business Days after the Department informing Contractor.

9.2.4.1.1. **PERFORMANCE STANDARD**: 90% of Providers who expressed a complaint to the Department are outreached by Contractor within two Business Days of the Department informing Contractor of the complaint. 98% of Providers who expressed a complaint to the Department are outreached by Contractor within five Business Days of the Department informing Contractor of the complaint.

9.2.5. Contractor shall establish a process for tracking and responding to and expeditiously resolving Provider complaints submitted to Contractor and the Department.

9.2.5.1. Contractor shall utilize a formal tracking mechanism that easily enables Providers to follow up with Contractor regarding a specific complaint submitted to Contractor.

9.2.5.2. For Provider issues that cannot be resolved within five Business Days, Contractor shall document a process for how Contractor is working to resolve the issue and provide a weekly update to the Department, either in writing or during a regularly scheduled meeting.

9.2.5.2.1. For inquiries that take longer than five Business Days to resolve, Contractor shall provide a specific name and contact information for a staff person that Provider will work with to resolve the issue. Contractor shall provide the staff member name and contact information via the method of communication the Provider used to contact Contractor.

9.2.5.2.2. **PERFORMANCE STANDARD**: 80% of Network Provider complaints submitted to the Department or Contractor shall be resolved by Contractor, as determined by the Department, within 20 Business Days after Contractor's receipt of Provider complaint.

9.2.5.3. Contractor shall collaborate with the Department on how to best communicate with and work with Network Providers who regularly submit multiple complaints, escalations, and communications, including determining when it may be appropriate to establish signed communications plans with a Network Provider establishing clear processes and expectations regarding communications.

9.2.6. Contractor shall assist any Provider who contacts Contractor, including Providers not in Contractor's region, who need assistance determining which Members are attributed to the Provider's practice.

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

9.2.7. Contractor shall use a variety of communication methods, including, at minimum, email lists and newsletters to communicate with Network Providers and Subcontractors and inform them of relevant Medicaid information and changes to any of Contractor's or the Department's policies and programs.

9.2.8. Contractor shall have a defined process to monitor the effectiveness of communication with Network Providers and Subcontractors and to address communication deficiencies or crisis situations, including how Contractor shall increase staff, contact hours, or other steps Contractor shall take if existing communication methods for Network Providers are insufficient.

9.2.9. Contractor shall have a single point of contact to support the Behavioral Health independent provider network (IPN).

9.2.9.1. The single point of contact for the IPN shall have authority to factor in the IPN's concerns and considerations into Contractor policies and procedures.

9.2.9.2. The single point of contact for the IPN shall attend workgroups, forums, and meetings in which the IPN is the focus.

9.3. General Information and Administrative Support

9.3.1. Contractor shall have processes and procedures to provide informational support to Network Providers, while not duplicating existing materials.

9.3.2. Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for all of the following topics, at a minimum:

9.3.2.1. General information about Medicaid, the ACC, and Contractor's role and purpose, including details about Contractor's Care Coordination program.

9.3.2.2. The Department's process for handling appeals of physical health Adverse Benefit Determinations and Contractor's process for handling appeals of Behavioral Health Adverse Benefit Determinations.

9.3.2.3. Available Member resources, including the Member Provider directory.

9.3.2.4. Clinical resources, such as screening tools, clinical guidelines, evidence-based disease prevention and management resources, practice improvement activities, templates, trainings, and any other resources Contractor has compiled.

9.3.2.5. Community-based resources and inventories for health-related social needs, such as childcare, food assistance, services supporting elders, housing assistance, utility assistance, and other non-medical supports.

9.3.2.6. The Department's Value-Based Payment strategy and models available to Network Providers.

9.3.3. Contractor shall distribute information and provide technical assistance to complement the Department's efforts to help Network Providers understand the following Colorado Medicaid program information:

9.3.3.1. Medicaid eligibility.

9.3.3.2. Medicaid covered benefits.

9.3.3.3. State Plan services.

9.3.3.4. EPSDT.

9.3.3.5. HCBS waiver services.

9.3.3.6. Capitated Behavioral Health Benefit.

9.3.3.7. Claims and billing procedures.

9.3.3.8. Prescriber tool opioid risk mitigation module and affordability module.

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

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

9.3.4. Contractor shall inform Network Providers of key Department contractors and the roles and responsibilities of the different Department contractors, including:

9.3.4.1. Colorado Medicaid's fiscal agent.

9.3.4.2. Electronic Data Warehouse (EDW).

9.3.4.3. Enrollment broker.

9.3.4.4. Pharmacy Benefit Management System.

9.3.4.5. Provider Performance and Quality Measurement (PPQM).

9.3.4.6. Utilization Management.

9.3.4.7. Oral Health contractor.

9.3.4.8. NEMT administrators.

9.3.4.9. Case Management Agencies.

9.3.4.10. Nurse advice line.

9.3.4.11. Crisis Services System.

9.3.5. Contractor shall act as a liaison between the Department and the Department's other contractors, partners, and Providers.

9.3.6. Contractor shall outreach to and educate specialists and other Providers regarding the ACC, the role of Contractor, and the supports Contractor will offer to Providers in Contractor's region.

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

9.3.7.1. Medicaid Provider enrollment.

9.3.7.2. Member eligibility and coverage policies.

9.3.7.3. Service authorization and referral.

9.3.7.4. Member and PCMP assignment and attribution.

9.3.7.5. PCMP designation.

9.3.7.6. EPSDT benefits.

9.3.7.7. Prescriber tool opioid risk mitigation module and affordability module.

9.3.7.8. eConsult tool and benefit.

9.3.8. Contractor shall use, and recommend to Network Providers, medical management, clinical, and operational tools to promote optimal health outcomes and to control costs for Members. The suite of tools and resources should offer a continuum of support for Network Providers and the broader Health Neighborhood.

9.4. Provider Training

9.4.1. Contractor shall, at a minimum, develop trainings and host forums for ongoing training regarding the ACC and the services Contractor offers.

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

9.4.2.1. Contractor shall promote BHA's learning management system for all Providers delivering services under the capitated Behavioral Health benefit.

9.4.3. Contractor shall have processes and procedures to make available trainings and updates on the following topics to Network Providers at minimum, once every six months:

9.4.3.1. Colorado Medicaid eligibility and application processes.

9.4.3.2. Medicaid benefits.

9.4.3.3. Access to Care standards.

9.4.3.4. EPSDT.

9.4.3.5. Contractor's Population Management Strategic Plan, including Care Coordination models.

9.4.3.6. ASAM criteria.

9.4.3.7. Use and proper submission of BHA supported data collection and other tools, including the most current BHA data collection products that track SUD, crisis and mental health encounter data; the referrals and bed tracking tool; and the BHA Central Registry Medication Assisted Treatment tool.

9.4.3.8. Cultural and disability competency.

9.4.3.9. Language assistance education to better serve Members who speak languages other than English.

9.4.3.10. Federal and state nondiscrimination statues and regulations.

9.4.3.11. Member rights, Grievances, and Appeals.

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

9.4.3.13. Principles of recovery and psychiatric rehabilitation.

9.4.3.14. Trauma-informed care.

9.4.3.15. The Department's Value-Based Payment methodologies, at minimum, specifically during the time leading up to and during Contractor and Network Provider's contract execution and regular amendment process.

9.4.3.16. NEMT.

9.4.3.17. Fraud, Waste, and Abuse.

9.4.4. Contractor shall develop training or educational materials on how hospital staff can request assistance from Contractor in discharging Members to care in the community.

9.4.4.1. On a quarterly basis, Contractor shall share Contractor's trainings or educational materials on how hospital staff can request discharge assistance from Contractor to all hospital care discharge team members with whom Contractor works.

9.4.5. Contractor shall maintain a record of training activities it offers, including Provider attendance at "live" trainings and utilization of any web-based trainings, and submit to the Department upon request.

9.5. EPSDT Universal Screenings

9.5.1. Contractor shall assist the Department in ensuring EPSDT eligible populations receive regularly scheduled examinations and evaluations of their general physical and mental health, growth, development, and nutritional status, in accordance with 42 CFR Part 441 Subpart B.

9.5.2. In the support of this goal, Contractor shall:

9.5.2.1. Implement policies, training, and practice transformation activities for Network Providers that improve Colorado's compliance with "AAP Bright Futures" recommendations for preventive pediatric healthcare, also known as the "periodicity schedule," in primary care settings.

9.5.2.2. Implement policies, training, and care integration strategies into diverse child and youth settings including, but not limited to schools, crisis settings, and other community-based organizations.

9.5.2.3. Implement policies and procedures to promote the utilization of developmental, social, behavioral, and mental health screeners among all children and youth Members.

9.5.3. Contractor shall work with the Department and other Managed Care Entities to create an EPSDT Uniform Accountability Strategy describing best practices for all Managed Care Entities to follow to ensure state compliance with EPSDT.

9.5.3.1. In developing an EPSDT Uniform Accountability Strategy, Contractor shall leverage Department provided resources that include, but are not limited to:

9.5.3.1.1. National experts.

9.5.3.1.2. National landscape and best practices.

9.5.3.1.3. Data and systems support to execute on plan.

9.5.3.2. Contractor shall participate in creating an EPSDT Uniform Accountability Strategy that shall include, but is not limited to:

9.5.3.2.1. Training and outreach plan on improving performance, including how Managed Care Entities will educate and provide practice transformation support to Providers on using the screening tools developed according to § 27-62-103, C.R.S., which required the state, in partnership with the community, to select developmentally appropriate and culturally competent statewide Behavioral Health standardized screening tools for primary care Providers.

9.5.3.2.2. Plans for engaging Providers and places of service across the community (e.g. schools, crisis Providers) to promote the early identification of child and youth conditions where families are most often seeking services.

9.5.3.2.3. Recommendations for identifying positive screens and tracking referrals to Treatment; and

9.5.3.2.4. Contractor reporting and partnership commitment to improve EPSDT screening and referral to treatment compliance.

9.5.3.3. Contractor shall work with the Department and other MCEs to complete the EPSDT Uniform Accountability Strategy within six months after the Effective Date.

9.5.3.4. Contractor shall implement the Department-approved EPSDT Uniform Accountability Strategy within 90 days of being directed in writing by the Department.

9.5.4. Contractor shall have policies and procedures to support and educate Network Providers on the utilization of evidence-based screening tools, including screening tools designed to identify needs of children and youth with other systems involvement or comorbidities.

9.5.4.1. Contractor shall ensure that its network includes Providers who are trained on the use of the different approved screening tools to align with reliability and validity.

9.5.5. Contractor shall support and train Providers to deliver active monitoring and follow up or refer a child or youth to a Behavioral Health Provider following a positive Behavioral Health screen as indicated by level of severity under AAP Bright Futures.

9.5.6. Contractor shall have documented policies and procedures to educate and support Providers with referring children and youth with any screen that indicates a significant level of severity to an appropriate Provider for follow up care within 30 days of identified need. This includes but is not limited to positive screens, for the following:

9.5.6.1. Behavioral Health.

9.5.6.2. Development.

9.5.6.3. Physical Health.

9.5.6.4. Vision.

9.5.6.5. Dental.

9.5.6.6. Early intervention.

9.5.7. Contractor shall work with the Department to design, implement, and utilize any and all state data systems being used to identify children and youth with a screen that indicates the presence of a condition (i.e. a positive screens) and that Contractor is able to track child and youth referrals to appropriate specialty care.

9.6. Data Systems and Technology Support

9.6.1. Contractor shall have expertise to support Providers in implementing and utilizing health information technology (HIT) systems and data. Contractor shall keep up to date with changes in HIT in order to best support Providers.

9.6.2. Contractor shall educate and inform Network Providers about the Department's and Contractor's data reports and systems available to the Providers and the practical uses of the available reports and tools.

9.6.3. Contractor shall make available technical assistance and training for Network Providers on how to use the following state-supported HIT systems in complement to existing Department efforts:

9.6.3.1. Contractor's Care Coordination Tool.

9.6.3.2. The EDW and PPQM Systems.

9.6.3.3. interChange.

9.6.3.4. BHA's data collection products that track SUD, crisis, and mental health encounter data.

9.6.3.5. PEAK website and PEAKHealth mobile app.

9.6.3.6. Regional health information exchange.

9.6.3.7. Electronic consultation and referral tools.

9.6.3.8. Prescriber tool.

9.6.3.9. SHIE.

9.6.3.10. BHA's referral and bed tracking tool and Medication Assisted Treatment Central Registry.

9.6.3.11. Provider portal.

9.6.3.12. Department provided Value-Based Payment related portal and dashboards.

9.6.4. Contractor shall participate in and encourage Network Provider participation in learning collaboratives or other regional or statewide meetings on state and Department efforts to advance HIT systems and data aggregators in Colorado.

9.6.4.1. Contractor shall identify opportunities to complement and support state and Department hosted meetings and facilitate gatherings in Contractor's assigned region upon the Department's request and as Contractor deems appropriate.

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

9.6.5.1. Provide practice-level data, reports, and/or assist Network Providers in utilizing Department provided data and reports.

9.6.5.2. Train Network Providers on how to utilize data to:

9.6.5.2.1. Succeed in the Department administered Value-Based Payment models.

9.6.5.2.2. Improve care for complex Members.

9.6.5.2.3. Improve Transitions of Care.

9.6.5.2.4. Improve care for Members with Department identified health conditions.

9.6.5.2.5. Implement wellness and prevention strategies.

9.6.5.2.6. Reduce inappropriate and inefficient care.

9.6.5.2.7. Understand how their practice is performing on KPIs and other health outcome measures.

9.6.5.2.8. Identify Members who require additional services.

9.6.5.3. Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the Network Providers, both Behavioral Health claims from Contractor's internal system and physical health claims data from the Department.

9.6.5.3.1. Contractor shall establish and implement a process for Network Providers to request raw claims data extracts from Contractor.

9.6.6. State Supported HIT Systems

9.6.6.1. Contractor shall provide technical and other support to Network Providers to increase the adoption and utilization rates of all state-supported HIT systems.

9.6.6.2. Contractor shall keep track of which Network Providers do not have specific tool functionality for state-supported HIT systems within their electronic health records (EHRs) and periodically share this list with the Department.

9.6.6.3. eConsult

9.6.6.3.1. Contractor shall encourage PCMPs to adopt and utilize the Department's eConsult platform, or other Department approved platforms, to expand the accessibility of specialist care to Members and enhance the PCMPs' capacity to provide comprehensive care to Members.

9.6.6.3.2. Contractor shall provide targeted outreach and workflow support to PCMPs who care for Members with limited access to transportation and/or who live in rural and frontier areas to increase adoption of eConsult and to try and provide as much care as possible through the PCMP, reducing the need for Members to travel for services that can be coordinated and managed effectively by the PCMP.

9.6.6.3.3. Contractor shall promote eConsult tools to specialty care Providers in Contractor's assigned region to increase the participation of specialty care Providers in eConsults and to improve specialty care Provider workflows, experience of care, and Member no-show rates.

9.6.6.3.4. Contractor shall coordinate with the Department and the Department's eConsult vendor on eConsult, sharing lessons learned and reporting challenges faced by Network Providers and Health Neighborhood Providers in the adoption and utilization of eConsult.

9.6.6.3.5. **PERFORMANCE STANDARD**: Contractor shall achieve a two percentage point annual increase in adoption of the eConsult benefit by PCMPs using any Department-approved platform. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

9.6.6.3.6. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed-upon percent of PCMPs who have adopted a Department-approved platform who also submitted an eConsult within the past 12 months. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

9.6.6.4. SHIE

9.6.6.4.1. Contractor shall disseminate information and provide technical assistance to Network Providers and the Health Neighborhood about the SHIE and promote the adoption of the SHIE and associated interoperable technologies for referring Members to health improvement programs and community resources for health-related social needs.

9.6.6.4.2. Contractor shall support Network Providers with incorporating utilization of the SHIE within practice workflows.

9.6.6.4.3. Contractor shall establish processes with Network Providers regarding when and how Contractor can assist, follow-up, and/or wraparound additional services for Members referred for programs through the SHIE.

9.6.6.4.4. **PERFORMANCE STANDARD**: Contractor shall achieve a Department and MCE agreed-upon improvement target for training and supporting Network Providers and Health Neighborhood entities in accessing and using the SHIE. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

9.6.6.5. Health Information Exchange (HIE)

9.6.6.5.1. Contractor shall incentivize Network Providers to be connected to the state's health information exchange (HIE) for exchanging clinical alerts, clinical quality measures data, and the bidirectional exchange of patient health information, including clinical care documents (CCDs) and Health Level Seven (HL7) data standards for admit and discharge data. All electronic submissions to the HIE must include all patient data, including behavioral health data and data covered by 42 CFR Part 2 if applicable.

9.6.6.5.1.1. Contractor shall promote the use of Office of the National Coordinator for Health Information Technology (ONC) Interoperability Standards for PCMP EHR systems, to improve data exchange. These standards are at https://www.healthit.gov/policy-researchers-implementers/interoperability.

9.6.6.5.1.2. Contractor shall assist Network Providers in accessing all available resources, such as the Clinical Health Information Technical Advisor (CHITA) support, to increase transfer of clinical documents (CCDs) to support accurate reporting of CMS Core Measures.

9.6.6.5.1.3. Contractor shall identify and address gaps in information sharing or data quality among Network Providers, Contractor, and the Department.

9.7. Practice Transformation

9.7.1. Contractor shall offer practice transformation support to Network Providers interested in improving performance and participating in Value-Based Payment models.

9.7.2. Contractor shall make available to Network Providers individualized practice coaching on topics that include, but are not limited to, the following

9.7.2.1. Team-based care and leveraging all staff to provide services within their full scope of practice.

9.7.2.2. Improving business practices and workflow.

9.7.2.3. Continuous quality improvement coaching and education on the delivery of evidence-based medicine.

9.7.2.4. Financial planning for quality-based payments and non-traditional payment arrangements, such as prospective payments.

9.7.2.5. Coordinating and integrating primary care and Behavioral Health services.

9.7.2.6. Incorporating lay health workers, such as promotoras, peers, community health workers, and patient navigators in accordance with the implementation of § 25.5-5-334, C.R.S.

9.7.2.7. Addressing Members' health related social needs.

9.7.2.8. Implementing health programming to advance Contractor's Population Management Strategic Plan.

9.7.2.9. Activities designed to improve Member health and experience of care.

9.7.3. Contractor shall partner with any interested Network Provider to identify the existing strengths of the Network Provider and to design and implement practice transformation strategies that build on these strengths and support the Network Provider in achieving the Network Provider's individualized practice goals.

9.7.4. Contractor shall participate as a full member of the Colorado Health Extension System to effectively leverage and align Contractor's activities statewide practice transformation programs and initiatives available and reduce administrative burden and duplication of activities for Network Providers.

9.7.5. Contractor shall incentivize PCMP participation in practice transformation activities utilizing the PCMP Payment Program and pay-for-performance payments.

9.7.6. Contractor shall collaborate with the Department and stakeholders around the design and implementation of a PCMP assessment tool that inventories, evaluates, and captures information about a PCMP's unique capabilities within CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models.

9.7.6.1. Contractor shall assess Contractor's PCMPs at minimum, one time annually using the Department-approved standardized PCMP assessment tool. Contractor shall partner with the Department and PCMPs to continually improve the PCMP Practice Assessment Tool and reduce the administrative burden on PCMPs.

9.7.6.2. Contractor shall collaborate with the Department on developing a reporting template that communicates the continuum of competencies for Contractor's network of PCMPs, including the provision of integrated physical and behavioral health, and how the network competencies of PCMPs are advancing over time.

9.7.6.2.1. Contractor shall identify PCMPs who provide integrated physical and behavioral health care based on the PCMP Practice Assessment Tool and submit information in a manner and format approved by the Department to add this information to the interChange Provider file.

9.7.6.3. **PERFORMANCE STANDARD**: Contractor shall show the PCMP Network's year-over-year progression along CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models based on results of the PCMP Practice Assessment Tool.

9.7.7. 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 as defined in the research literature and supporting the identification and analysis of service overutilization.

9.7.8. Contractor shall partner with interested Network Providers to establish and document feasible, measurable transformation goals that best fit a practice's overall operational strategy. Based on the practice's goals, Contractor shall develop a practice transformation plan to:

9.7.8.1. Connect Network Providers to practice transformation resources that are readily available in the region, such as those available through the Colorado Health Extension System.

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

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

9.7.8.4. Measure the Network Provider's progress against the identified transformation goals.

9.7.9. Contractor shall use existing practice transformation and support organizations in the region and the state and coordinate with existing efforts, when appropriate, to reduce duplication of efforts and overburdening practices.

9.7.10. Contractor's practice transformation activities that should be available ongoing to any interested Network Provider shall include, but not be limited to:

9.7.10.1. Sharing Contractor-developed chronic condition and health improvement programs.

9.7.10.2. Sharing actionable data with Network Providers to improve their ability to prioritize Care Coordination and member engagement.

9.7.10.3. Working with Network Providers to meet regional access, quality (CMS Core Measures), and other outcome and equity goals, including the Department's health equity plan goals.

9.7.10.4. Supporting Network Providers with either implementing new or improving existing integrated physical and behavioral health care activities.

9.7.10.5. Establishing processes for improved coordination with and referrals to specialty care Providers.

9.7.10.6. Working with Network Providers to develop and/or utilize Care Coordination and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary ED use and total cost of care.

9.7.10.7. Assisting Network Providers on integrating new tools and best practices into their workflows, such as utilizing eConsults, the Prescriber Tool OpiSafe and Real-Time Benefits Inquiry (RTBI) modules, SHIE, emerging cost and quality indicators, and other innovations that evolve through Phase III of the ACC.

9.7.10.8. Helping Network Providers utilize and leverage state investments in rural health, such as the Department's implementation of Senate Bills 22-200 and 23-298.

9.7.11. Value-Based Payment Practice Support Activities

9.7.11.1. Contractor shall provide practice support that enables Network Providers to adopt and be successful in Value-Based Payment models through improving quality of care and health outcomes and transitioning Providers financial model.

9.7.11.2. Contractor shall support Network Providers participation in the Department's and Contractor's Value-Based Payment models for both Behavioral Health and primary care.

9.7.11.3. Contractor shall support the success and sustainability of Network Providers in transitioning away from historical fee-for-service models in accordance with the Department's Value-Based Payment strategy and any Department rules and regulations.

9.7.11.3.1. Contractor shall serve as an essential resource to help Network Providers maximize payment by improving Network Providers' performance on health outcome metrics.

9.7.11.3.2. Contractor shall support Network Providers with understanding how their payments can vary based on performance on health outcome goals, and then provide practice transformation activities to enable the interested Network Providers to achieve the performance goals.

9.7.11.3.3. Contractor shall have sufficient knowledge to effectively support PCMPs with different types of funding, such as Federally Qualified Health Centers, Rural Health Centers, or Comprehensive Providers, or will partner with the appropriate organizations to sufficiently support these types of PCMPs.

9.7.11.3.4. Contractor's ability to earn performance payments and shared savings are dependent upon Contractor's successful support of Network Providers in achieving Value-Based Payment goals and metrics.

9.7.11.4. Contractor's Value-Based Payment practice support activities shall include, but not be limited to:

9.7.11.4.1. Educating Network Providers about all Value-Based Payments available to the Provider.

9.7.11.4.2. Provision of actionable data to support achieving CMS core metric performance at Department designated benchmarks.

9.7.11.4.3. Clinical and process strategies to successfully reach quality targets and earn Value Based Payments.

9.7.11.4.4. Individualized support on strategies to promote financial sustainability, including:

9.7.11.4.4.1. Explanations of and considerations for practice transition to prospective payments, quality-based payments, per-member-per months (PMPMs), shared savings, and other non- traditional revenue streams.

9.7.11.4.4.2. Budgeting and accounting considerations for payment transition.

9.7.11.4.4.3. Best practices for reconciliation of prospective payments to utilization.

9.7.11.5. Contractor shall participate in Value-Based Payment initiatives, meetings, trainings, and strategic planning lead by the Department, BHA, and CDOI.

9.7.11.6. Contractor shall designate staff and communication methods, such as a dedicated phone line, email address, or web-based form for the exclusive purpose of providing support to Network Providers and responding to Network Provider questions regarding the Department's primary care Value-Based Payment models, as well as Contractor's and the Department's Value-Based Payment models for Behavioral Health.

9.7.11.7. Contractor shall serve as an essential resource to help PCMPs understand their Department generated payment rates in the Department's Value-Based Payment programs.

9.7.11.7.1. Contractor shall be the primary point of contact for PCMPs to explain the rates and the rate calculation methodology. Contractor shall serve as the primary point of questions. For questions which Contractor cannot answer, Contractor shall refer those questions to the Department for further clarification.

9.7.11.8. Based on the needs of Contractor's assigned region and the existing practice transformation resources available, Contractor shall offer trainings, learning collaboratives, and/or other resources to support practices in participating in the Department's Value-Based Payment models.

9.7.11.8.1. Contractor shall leverage Department tools and resources for trainings to reduce Provider confusion and promote consistency around the models.

9.7.11.9. Contractor shall design and implement a documented RAE Annual Shared Savings Strategy to maximize Contractor's and Network Providers' attainment of shared savings within the region.

9.7.11.9.1. Contractor shall submit the RAE Annual Shared Savings Strategy to the Department for review and approval. The RAE Annual Shared Savings Strategy shall include:

9.7.11.9.1.1. An assessment of impactable costs in the region.

9.7.11.9.1.2. The prioritized areas of opportunity for shared savings.

9.7.11.9.1.3. The strategies Contractor shall take to positively impact shared savings, including provider support and communication strategies to promote collaboration among relevant Health Neighborhood providers.

9.7.11.9.1.4. Contractor's plan to mitigate the risks of unintended negative consequences of the RAE Annual Shared Savings Strategy, such as reduction in preventative care.

9.7.11.9.1.5. How Contractor will measure if their strategy is working.

9.7.11.9.1.5.1. **DELIVERABLE**: RAE Annual Shared Savings Strategy

9.7.11.9.1.5.2. **DUE**: September 15, 2025 and then Annually, by June 1

9.7.11.9.2. Following the initial year of the Work, Contractor shall submit the RAE Annual Shared Savings Strategy Report to the Department describing Contractor's efforts to maximize shared savings within the region, the results of those activities, including

the identified metrics from the initial Strategy Plan, lessons learned and best practices at the PCMP level, and how Contractor may modify Contractor's shared savings strategy for the next year. An appendix shall be included listing all PCMPs participating in the shared savings program, the level of engagement, earned PCMP shared savings payments, as well as any PCMPs that declined support.

9.7.11.9.2.1. **DELIVERABLE**: RAE Annual Shared Savings Strategy Report

9.7.11.9.2.2. **DUE**: Annually, as determined by the Department.

9.7.11.9.3. Contractor may be eligible to retain a percentage of shared savings generated as an incentive to support PCMP success in their region. Contractor shall demonstrate in the RAE Annual Shared Savings Strategy Report that they have implemented region-wide strategies that positively impact cost.

9.8. Financial Support

9.8.1. Contractor shall promote the reduction in administrative burden on Network Providers by aligning Contractor's practice support initiatives to Department-approved national and state Value-Based Payment models, including, but not limited to:

9.8.1.1. Colorado Division of Insurance's Primary Care Alternative Payment rules and regulations.

9.8.1.2. The Department's implementation of the Center for Medicare & Medicaid Innovations (CMMI's) Making Care Primary model.

9.8.1.3. Behavioral Health Value-Based Payment models.

9.8.2. Contractor shall design and implement Behavioral Health Value-Based Payment arrangements and practice support activities in accordance with Department-approved models and the Behavioral Health Administration's rules and regulations.

9.8.3. PCMP Payment Program

9.8.3.1. Contractor shall design and implement a PCMP Payment Program for PCMP Network Providers to complement the Department's Primary Care Alternative Payment Models and to improve PCMPs' ability to deliver high-quality health outcomes for Members and maximize payment.

9.8.3.1.1. Contractor's PCMP Payment Program shall include strategies and operations for distributing the following types of payments:

9.8.3.1.1.1. Prospective payments varied by Member acuity.

9.8.3.1.1.2. Pay for performance payments.

9.8.3.1.2. Contractor's PCMP Payment Program shall be designed to achieve, at minimum, all of the following:

9.8.3.1.2.1. Increase equitable Member access to adult and pediatric primary care.

9.8.3.1.2.2. Incentivize PCMPs to participate in practice transformation activities and progress along the continuum of advanced primary care in alignment with CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models, while minimizing administrative burden on the PCMP.

9.8.3.1.2.3. Incentivize PCMPs to deliver more intensive Care Coordination interventions for higher acuity Members while reporting Care Coordination data elements outlined in Section 8.

9.8.3.1.2.4. Incentivize PCMP adoption and utilization of Department and state supported health technologies, such as the Prescriber Tool and eConsult.

9.8.3.2. Contractor's PCMP Payment Program shall incorporate the following funding opportunities for PCMPs:

9.8.3.2.1. Three-tier PCMP Medical Home payment based on the Department-approved PCMP Practice Assessment Tool.

9.8.3.2.2. Integrated care payment for practices that meet set standards regarding the integration of primary care and behavioral health care as set forth in the PCMP Practice Assessment Tool

9.8.3.2.3. Care Coordination payment based on a PCMP's ability and willingness to be responsible for and report on Care Coordination provided to attributed Members.

9.8.3.2.4. Member acuity payment that offers PCMPs increased funding for Members determined to have increased needs.

9.8.3.2.5. Contractor-determined payment that may support other activities that further the goals and priorities of the Department and ACC.

9.8.3.3. Medical Home payment

9.8.3.3.1. Similar to the CDOI Primary Care Alternative Payment Model and CMMI's Making Care Primary program, Contractor shall design and implement a three tier Medical Home payment framework in accordance with Department guidelines.

9.8.3.3.1.1. Contractor shall utilize the Department-approved PCMP Practice Assessment Tool to assess PCMP capabilities and determine the payment tier for which a PCMP qualifies.

9.8.3.3.1.1.1. Contractor shall have PCMPs complete the PCMP Practice Assessment Tool and attest to their capabilities.

9.8.3.3.1.1.2. Contractor shall annually audit at minimum 10% of PCMPs self assessments and adjust a PCMP's payment tier as appropriate.

9.8.3.3.1.1.3. Contractor shall not recoup PCMP payments distributed to a PCMP prior to Contractor's audit of a PCMP's payment tier.

9.8.3.3.1.1.4. Contractor's determination of a PCMP's payment tier shall be considered final.

9.8.3.4. Integrated care payment

9.8.3.4.1. Contractor shall design a payment strategy to complement the Department's efforts to promote and increase the integration of behavioral health services in primary care settings.

9.8.3.4.2. Contractor shall use the PCMP Practice Assessment Tool to identify where PCMPs are along the continuum of integrated care.

9.8.3.4.2.1. Contractor shall submit a report to the Department identifying PCMPs who meet any of the criteria as an integrated care PCMP.

9.8.3.4.2.2. Contractor shall provide reimbursement to PCMPs who meet minimum Department-specified criteria as an integrated care PCMP.

9.8.3.5. Care Coordination payment

9.8.3.5.1. Contractor may distribute funding to PCMPs who are capable of and are committed to providing advanced levels of Care Coordination beyond the basic Medical Home standards of Care Coordination.

9.8.3.5.2. Contractor shall require PCMPs that receive a Care Coordination payment to have mechanisms to routinely report to the RAE information on individual Member Care Coordination activities.

9.8.3.5.3. Contractor shall report contracted Care Coordination relationships with PCMPs in the Care Coordination Roles Report.

9.8.3.6. Member acuity payment

9.8.3.6.1. Contractor shall design and implement a methodology that provides increased funding to PCMPs for those Members with complex health needs.

9.8.3.6.2. Contractor's methodology shall incentivize PCMPs to accept and to serve longitudinally as a focal point of care for Members with complex health needs.

9.8.3.7. Contractor-determined payment

9.8.3.7.1. Contractor may design and implement innovative payment strategies designed to further achievement of Department goals and priorities. For example, Contractor may offer financial support for activities such as sustaining established quality standards, providing disability accessible equipment and access, employing practitioners who speak languages other than English, and reporting clinical quality metrics.

9.8.3.7.2. Contractor's unique payment strategies shall not duplicate or conflict with the Department pay-for-performance program.

9.8.3.8. Contractor shall make payments directly to PCMP Network Providers from Contractor's care management PMPM payment in accordance with Contractor's PCMP Payment Program.

9.8.3.8.1. Contractor shall distribute, in aggregate, at least 33% of Contractor's care management PMPM payments received from the Department to Contractor's PCMP Network Providers.

9.8.3.9. Contractor shall collaborate with the Department to determine how pay for performance and shared savings payments will be distributed by Contractor to participating Network Providers. The Department will calculate and direct how certain payments will be awarded and distributed to participating Network Providers.

9.8.3.10. Contractor shall detail individual PCMP payment arrangements in their written contract with the Network Provider.

9.8.3.11. Contractor shall provide stakeholders with opportunities to participate in and provide input toward the development of Contractor's PCMP payment program.

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

9.8.4. PCMP Access Stabilization Payment

9.8.4.1. Pending state and federal authority, Contractor shall implement the Department's access stabilization payment program for qualifying rural, pediatric, and small clinic PCMPs.

9.8.4.2. Contractor shall distribute access stabilization payments to Department identified PCMPs who qualify.

9.8.4.3. Contractor shall distribute 100% of PCMP access stabilization funding received from the Department to individual PCMPs in accordance with Department distribution specifications and the monthly PCMP access stabilization payment report.

9.8.5. Financial, Programmatic, and Resource Support for Rural Providers

9.8.5.1. Contractor shall design and implement strategies to enhance financial and technical support of Network Providers and other Providers in rural communities to complement the Department's implementation of Senate Bill 22-200 and Senate Bill 23-298 and other work identified by the Department and Contractor to support the sustainability of rural and CEAC health services and to better manage care for Members living in rural and CEAC areas.

9.8.5.2. Contractor shall provide shared resources, condition management programming, supporting communication tools, and population health analytics at no cost to small independent Providers and rural Providers including RHCs, to the extent a Provider doesn't have these resources and is willing to partner with Contractor.

9.8.5.3. Contractor may fund investments in needed and shared infrastructure and services across rural hospitals and rural clinics that may include Care Coordination models, software, technology upgrades, and assistance connecting to, maintaining, and utilizing state HIT systems, particularly the state HIEs.

9.8.6. Pay for Performance

9.8.6.1. Contractor shall collaborate with the Department to determine how pay for performance and shared savings payments will be distributed by Contractor to participating Network Providers. The Department will calculate and direct how certain payments will be awarded and distributed to participating Network Providers.

9.8.6.2. Contractor shall comply with Department guidance and specifications to implement a statewide PCMP KPI incentive program.

9.8.6.2.1. Contractor shall educate PCMPs about the PCMP KPI incentive program and the two payment tracks PCMPs could be eligible for:

9.8.6.2.1.1. KPI performance track that rewards PCMPs for individual practice performance on a set of up to six CMS core measures.

9.8.6.2.1.2. KPI practice transformation track for practices that may not qualify for the full set of 6 metrics under the KPI performance track but are interested in completing quality improvement activities.

9.8.6.2.1.2.1. PCMPs that qualify for only four or five metrics of the KPI performance track may participate in both the KPI performance track and the KPI practice transformation track as specified by the Department.

9.8.6.2.2. Contractor shall provide PCMPs participating in the PCMP KPI performance track with RAE coaches that will help PCMPs with, at a minimum the following:

9.8.6.2.2.1. Understanding quality metric target thresholds.

9.8.6.2.2.2. Identifying and improving workflows that focus on achieving PCMP KPI metric thresholds.

9.8.6.2.2.3. Improving billing.

9.8.6.2.2.4. Using data and analytics, including information available through the PPQM regarding PCMP performance against quality metric target thresholds.

9.8.6.2.2.5. Identifying and achieving cost goals for those PCMPs participating in Shared Savings.

9.8.6.2.3. Contractor shall perform, at a minimum, the following activities for PCMPs participating in the PCMP KPI practice transformation track:

9.8.6.2.3.1. Approve PCMP identified practice transformation projects

9.8.6.2.3.2. Conduct coaching session with PCMP at least two times per quarter.

9.8.6.2.3.3. Monitor completion of the Department established minimum number of quality improvement activities per quarter.

9.8.6.2.3.4. Approve quality improvement tools (e.g., root cause analysis).

9.8.6.2.3.5. Facilitate quality improvement meetings.

9.8.6.2.3.6. Collaborate on implementation.

9.8.6.2.3.7. Provide resources.

9.8.6.2.3.8. Build a peer network.

9.8.6.2.4. Contractor shall document a PCMP's KPI incentive track participation in Contractor's written contract with the PCMP.

9.8.6.2.4.1. Contractor shall allow PCMPs to choose not to participate in the PCMP KPI practice transformation track and relinquish their right to additional payment based on performance.

9.8.6.2.4.2. Contractor shall submit a report to the Department identifying PCMPs participating in the KPI practice transformation track.

9.8.6.2.4.2.1. **DELIVERABLE**: PCMP KPI Practice Transformation Track Participation

9.8.6.2.4.2.2. **DUE**: Annually, by August 1

9.8.6.2.5. Contractor shall submit a quarterly report to the Department identifying which PCMPs participating in the PCMP KPI practice transformation track have completed the Department established minimum number of quality improvement activities for the quarter and are therefore eligible to receive a PCMP KPI incentive payment.

9.8.6.2.5.1. **DELIVERABLE**: Quarterly PCMP KPI Practice Transformation Track Report

9.8.6.2.5.2. **DUE**: Quarterly, by the last business day of July, October, January, and April

9.8.6.2.6. Contractor shall distribute PCMP KPI incentive payments to PCMPs as designated by the Department.

9.8.6.2.7. Contractor shall collaborate with the Department to design and implement novel ways to promote improved performance on KPIs at the Provider, Contractor, and state level.

9.9. Reporting Requirements

9.9.1. RAE Administrative Payment Report

9.9.1.1. As part of the Annual Contracted Network Management Strategic Plan, Contractor shall submit to the Department for review and approval a detailed reporting of the PCMP Payment Program and payment strategy to be established with contracted Health Neighborhood Providers and CBOs. This information shall be reported as administrative payments made in the Quarterly Financial Report.

9.9.1.2. Contractor shall submit a RAE Administrative Payment Report to the Department any time Contractor makes changes to its payment arrangements with Network Providers and Health Neighborhood Providers.

9.9.1.2.1. **DELIVERABLE**: RAE Administrative Payment Report

9.9.1.2.2. **DUE**: Within 30 days prior to the new changes to payment arrangements taking effect

9.9.2. Provider Performance Statements

9.9.2.1. Contractor shall create and send to any Network Providers that they have a value-based payment contract with a quarterly Provider Performance Statement that offer detailed information about practice-level performance and Contractor's and the Department's value-based payments distributed to the Network Providers.

9.9.2.2. Contractor's Provider Performance Statements shall combine information generated by Contractor, the Department, and the Department's Value-Based Payment vendor.

9.9.2.3. Contractor's Provider Performance Statements shall include, but is not limited to, all of the following information:

9.9.2.3.1. Quality metric performance results calculated by the Department or its designated vendor.

9.9.2.3.2. Quality metric performance results calculated by Contractor.

9.9.2.3.3. Utilization data from the Department or Contractor that impacts the Network Provider's metric performance or payment.

9.9.2.3.4. Description of whether Provider's performance met criteria for payment for each specific quality metric.

9.9.2.3.5. Clear identification of payments distributed, including identification of any payments for achieving specific metric performance and advanced primary care tier.

9.9.2.3.6. Member-level data identifying how the Network Provider could intervene to achieve a specific performance metric and earn pay for performance payments. This could consist of a link or notification of data available through the PPQM or other available Department or Contractor resource

9.9.2.3.7. Recommendations of how Contractor can support the Network Provider to improve performance in the future.

9.9.2.4. Contractor shall support the dissemination of the Provider Performance Statement as timely as possible to enable Network Providers to take action before the performance period ends.

9.9.2.5. Contractor shall educate Network Providers on how to read the Provider Performance Statement, how to track and reconcile payments, how to understand the financial implications, and how to develop a plan for improvement.

9.9.3. Provider Satisfaction Survey

9.9.3.1. Contractor shall implement a Network Provider satisfaction survey to assess the effectiveness and usefulness of Contractor's Provider support, practice transformation, and Provider relations.

9.9.3.2. Contractor shall develop a Network Provider Satisfaction Survey Plan.

9.9.3.2.1. Contractor's Network Provider Satisfaction Survey Plan shall include the process by which Contractor shall assess Network Provider satisfaction, including how it will make the survey or tool available to Network Providers, how it will receive completed responses, how it will choose which Network Providers are included, and how it will maximize the response rate.

9.9.3.2.2. Contractor shall submit the Network Provider Satisfaction Survey Plan to the Department for review and approval.

9.9.3.2.2.1. **DELIVERABLE**: Network Provider Satisfaction Survey Plan

9.9.3.2.2.2. **DUE**: 30 days prior to the Operational Start Date

9.9.3.2.3. Contractor shall review its Network Provider Satisfaction Survey Plan annually with the Department to determine if any modifications are necessary, that the Network Provider satisfaction survey is accurately measuring the Network Provider's experience, and that the responses received are timely, in sufficient numbers, and applicable. Contractor shall make all required edits to the Network Provider Satisfaction Survey Plan based on this review or as directed by the Department.

9.9.3.2.3.1. **DELIVERABLE**: Updated Network Provider Satisfaction Survey Plan

9.9.3.2.3.2. **DUE**: Annually, by July 1

9.9.3.2.4. Contractor shall administer all Network Provider satisfaction surveys in accordance with Contractor's most recently approved Network Provider Satisfaction Survey Plan.

9.9.3.3. Contractor's Network Provider Satisfaction Survey shall measure Network Provider satisfaction with Contractor's Work in categories that include, but are not limited to, the following:

9.9.3.3.1. Customer service, including responsiveness, promptness, and ease to reach a satisfactory resolution for both digital and telephonic interactions with customer service representatives.

9.9.3.3.2. Effectiveness, accuracy, and applicability of Network Provider education training and materials.

9.9.3.3.3. Effectiveness and applicability of practice transformation efforts.

9.9.3.3.4. PAR processing and determinations.

9.9.3.3.5. Claims processing.

9.9.3.4. Contractor shall submit its Network Provider satisfaction survey data to the Department upon request for the Department's evaluation of results.

9.9.3.5. Contractor shall submit its evaluation of Network Provider satisfaction survey data and results to the Department. Contractor shall identify opportunities for improvements and describe Contractor's plans to address Network Provider needs through training, system updates, automation, etc. that are likely to improve Network Provider experience and result in better Member outcomes.

9.9.3.5.1. **DELIVERABLE**: Network Provider Satisfaction Survey Evaluation

9.9.3.5.2. **DUE**: Annually, on October 1.

10. CAPITATED BEHAVIORAL HEALTH BENEFIT

10.1. Overview

10.1.1. Contractor shall administer and deliver the Capitated Behavioral Health Benefit.

10.1.2. As the Administrator of the Capitated Behavioral Health Benefit for all Members assigned to Contractor pursuant to this Contract, Contractor shall, at minimum, perform all of the following:

10.1.2.1. Receive a Capitated Payment for each Member and ensure the Capitated Payments support Members achieving Behavioral Health and wellbeing and are not diverted for meeting Contractor's physical health responsibilities.

10.1.2.2. Employ strategic health care management practices described throughout the Contract in administering the Capitated Behavioral Health Benefit, create financial incentives to drive quality care, and have strong Member experience protections.

10.1.2.3. Administer the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the Work.

10.1.3. Contractor shall increase access to Behavioral Health services for all Members assigned to Contractor pursuant to this Contract, by, at minimum:

10.1.3.1. Assuming comprehensive risk for all covered inpatient and outpatient Behavioral Health services.

10.1.3.2. Taking full responsibility for providing, arranging for, or otherwise taking responsibility for the provision of all Medically Necessary covered Behavioral Health services.

10.1.4. Contractor shall administer the Capitated Behavioral Health Benefit in line with the following principles:

10.1.4.1. 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 Member 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.

10.1.4.2. Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

10.1.4.3. Least restrictive environment: The provision of community-based supports and services that enable Members with serious mental illness and other disabilities to live in the community to the greatest extent possible and as appropriate.

10.1.4.4. Prevention and early intervention: Broad community-wide efforts to reduce the impact of mental health and SUD on Members and communities that include, but are not limited to, all of the following:

10.1.4.4.1. Improving the public's understanding of mental health and SUD.

10.1.4.4.2. Normalizing mental health and SUD as legitimate and treatable health issues.

10.1.4.4.3. Normalizing primary care as an ideal setting for treating appropriate mental health and SUD.

10.1.4.4.4. Promoting education and public awareness of mental health and SUD symptoms.

10.1.4.4.5. Increasing access to effective treatment and supporting Member recovery.

10.1.4.5. Integrated care: Commitment to implementing integrated care approaches in line with Department initiatives.

10.1.4.6. Evidence-based: Treatment is provided in accordance with the established evidence-based practices and emerging promising practices.

10.1.4.7. Member and family centered care: Services and supports are provided in the best interest of the Member to ensure that the needs of the Member and family are being addressed. Systems, services, and supports are based, when appropriate, on the strengths and needs of the entire family or community.

10.1.4.8. Health equity and cultural responsiveness: Contractor shall consider factors related to health equity to ensure Members have access to culturally responsive, disability competent, and meaningful care.

10.1.5. Contractor is not required to reimburse for, or provide coverage for, a counseling or referral service that it would otherwise be required to provide, if Contractor objects to the service on moral or religious grounds, in accordance with 42 CFR § 438.102(b)(1)(i)(B) and 42 CFR § 438.10(g)(4).

10.1.5.1. Contractor shall furnish information about the services that Contractor does not cover because of moral or religious objections to the Department whenever Contractor adopts such a policy during the Term of the Contract.

10.1.5.2. If Contractor does not cover counseling or referral services because of moral or religious objections and chooses not to convey information on how and where to obtain such services, the Department shall provide that information to Members.

10.1.5.3. Contractor shall track Network Providers who do not offer Covered Services because the Provider objects to the services on moral or religious grounds in order for Contractor to

ensure Members understand Members' ability to access alternative services and can make Members' own fully informed choices.

10.1.6. Contractor shall document in a Department template and submit an Annual Behavioral Health Management Strategic Plan to the Department for review and approval. The Plan shall describe how Contractor will administer the Capitated Behavioral Health Benefit in accordance with Contract requirements without duplicating Contractor's reporting provided in other Contractor Deliverables, such as Contractor's Annual Network Management Strategic Plan and the Annual Population Management Strategic Plan.

10.1.6.1. **DELIVERABLE**: Annual Behavioral Health Management Strategic Plan

10.1.6.2. **DUE**: June 1, 2025 and annually on June 1 thereafter.

10.2. Covered Services

10.2.1. Contractor shall provide or arrange for the provision of all Medically Necessary Covered Services, as outlined in Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses and the most recent Statewide Behavioral Health Services Billing Manual posted on the Department's website at https://hcpf.colorado.gov/sbhs-billing-manual, which specifies the procedures and the Primary and Principal Diagnoses for which Contractor is responsible.

10.2.2. Contractor shall ensure access to care for all Members in need of Medically Necessary covered mental health and SUD 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 Members with intellectual and developmental disabilities.

10.2.3. Contractor shall provide or arrange for the provision of 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.

10.2.3.1. Continued Services to Members: Contractor shall comply with the state's transition of care policy to ensure the Member's continued access to services during a transition from one RAE to another RAE as required in 42 CFR § 438.62.

10.2.4. Contractor shall manage the delivery of the following state plan services for Members:

10.2.4.1. Hospital Services

10.2.4.1.1. Inpatient Psychiatric Hospital Services

10.2.4.1.1.1. Contractor's responsibility for all inpatient hospital services is based on the Principal Diagnosis that requires inpatient level of care.

10.2.4.1.1.2. Contractor shall cover and pay for Inpatient Psychiatric Services as follows:

10.2.4.1.1.2.1. For Members under 21 years old, in any facility licensed as a hospital by the state.

10.2.4.1.1.2.2. For Members ages 21 to 64, in a facility licensed as a hospital by the state, excluding facilities identified as IMDs.

10.2.4.1.1.2.3. For Members aged 65 years and older, in any facility licensed as a hospital by the state.

10.2.4.1.1.3. Contractor may cover, but may not require the Member to use, Institutes 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).

10.2.4.1.1.3.1. Short-term stays in an IMD associated with a psychiatric Principal Diagnosis must be for lengths of stay no more than 15 days during the period of the monthly capitation payment. When Members are in an IMD for more than 15 days, the Department will recoup the capitation payment. This length of stay limit does not apply to inpatient stays associated with a SUD diagnoses.

10.2.4.1.1.3.2. Contractor shall receive a monthly capitation payment for retroactively enrolled Members who received IMD services up to 90 days prior to their eligibility determination.

10.2.4.1.1.4. Acute Care/General Hospital Services

10.2.4.1.1.4.1. Contractor shall not be financially responsible for inpatient hospital services when the Member's Principal Diagnosis is physical in nature, regardless of whether the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis.

10.2.4.1.1.4.2. Contractor shall be financially responsible for the hospital stay when the Member's Principal Diagnosis is a covered psychiatric diagnosis, even when the diagnosis includes some physical health procedures (including labs and ancillary services).

10.2.4.1.1.4.2.1. Contractor shall be responsible for inpatient SUD services that include ASAM 3.7 or 3.7WM levels of care that provide a planned and structured regimen of 24-hour medically managed/monitored evaluation, observation, or addiction treatment in an inpatient setting.

10.2.4.1.1.4.2.2. Contractor shall not be financially responsible for ASAM level 4 services.

10.2.4.1.1.5. Freestanding Psychiatric Hospital

10.2.4.1.1.5.1. Short-term stays for a mental health diagnosis in a freestanding psychiatric hospital determined to be an IMD must be for lengths of stay of no more than 60 days for Members aged 21-64.

10.2.4.1.1.5.1.1. This length of stay limit does not apply to inpatient stays associated with SUD diagnoses.

10.2.4.1.1.5.2. Contractor shall receive a monthly capitation payment for retroactively enrolled Members who received IMD services up to 90 days prior to the Member's eligibility determination date.

10.2.4.1.1.6. Colorado Mental Health Hospitals

10.2.4.1.1.6.1. Treatment services provided in a State Hospital for Members under 21 years of age and over 65 years old.

10.2.4.1.2. Professional Hospital Services: Contractor shall be financially responsible for all professional services provided in a hospital when the procedure(s) is listed in the State Behavioral Health Services Billing Manual, 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.

10.2.4.1.3. 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.

10.2.4.1.3.1. Contractor shall be financially responsible for all Medicaid services associated with a Member's outpatient hospital treatment, including all psychiatric and associated medical and facility services, labs, x-rays, supplies, and other ancillary services, when the procedure(s) are billed on a UB-04 and ANSI 837-I X12 claim form, and the Principal Diagnosis is a covered psychiatric diagnosis.

10.2.4.1.3.2. Contractor shall be financially responsible for intensive outpatient program (IOP) services performed in outpatient hospital setting, when the procedure is billed on a UB-04 and ANSI 837-I X12 claim form, and the Principal Diagnosis is a covered Behavioral Health diagnosis.

10.2.4.2. Emergency Services and Post-Stabilization Care Services

10.2.4.2.1. Contractor shall cover and pay for Emergency Services and Post-stabilization Care Services, as specified in 42 CFR § 438.114(b) and 42 CFR § 422.113(c).

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

10.2.4.2.3. Contractor shall cover and pay a non-contracted Provider for Emergency Services no more than the amount that would have been paid if the service had been provided by a Network Provider.

10.2.4.2.4. Contractor shall not be responsible for outpatient emergency room services billed on a UB-04 for the treatment of a primary substance use disorder.

10.2.4.2.5. Contractor shall be responsible for practitioner emergency room claims billed on a CMS-1500, when the procedure(s) is listed in the State Behavioral Health Services Billing Manual, and the Primary Diagnosis is a covered Behavioral Health diagnosis when a diagnosis is required.

10.2.4.2.6. Contractor shall not refuse to cover treatment obtained under either of the following circumstances:

10.2.4.2.6.1. A Member had an emergency medical condition in which the absence of immediate medical attention would not necessarily have had the outcomes specified in the definition of Emergency Medical Condition.

10.2.4.2.6.2. A representative of Contractor instructs the Member to seek Emergency Services.

10.2.4.2.7. Contractor shall allow Members to obtain Emergency Services outside the primary care case management system regardless of whether the case manager referred the Member to the Network Provider that provided the services.

10.2.4.2.8. Contractor shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or Fiscal Agent not notifying Contractor of the Member's screening and treatment within ten calendar days after the Member's presentation for Emergency Services.

10.2.4.2.9. Contractor shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

10.2.4.2.10. Contractor shall acknowledge and commit to demonstrating that the attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, which determination is binding on Contractor for coverage and payment.

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

10.2.4.2.12. Contractor shall be financially responsible for Post-Stabilization Care Services, as defined in Section 10.2.4.2, obtained within or outside Contractor's network that are not pre-approved by Contractor but are administered to maintain, improve, or resolve the Member's stabilized condition if any of the following are true:

10.2.4.2.12.1. Contractor does not respond to a request for pre-approval within one hour.

10.2.4.2.12.2. Contractor cannot be contacted.

10.2.4.2.12.3. Contractor and the treating Provider cannot reach an agreement concerning the Member's care and a Network Provider is not available for consultation. In this situation, Contractor shall give the treating Provider the opportunity to consult with a Network Provider and the treating Provider may continue with care of the Member until a Network Provider is reached or one of the criteria in 42 CFR § 422.113(c)(3) is met.

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

10.2.4.2.14. Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved shall end when any of the following occur:

10.2.4.2.14.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Member's care.

10.2.4.2.14.2. A Network Provider assumes responsibility for the Member's care through transfer.

10.2.4.2.14.3. Contractor and the treating Provider reach an agreement concerning the Member's care.

10.2.4.2.14.4. The Member is discharged.

10.2.4.2.15. Nothing in Section 10.2. shall preclude Contractor from conducting a retrospective review consistent with these requirements regarding Emergency and Post-Stabilization Care Services.

10.2.4.2.16. Contractor shall be financially responsible for Emergency Services when the Member's Primary or Principal Diagnosis is a covered psychiatric diagnosis, even when some physical health conditions are present, or a medical procedure is provided.

10.2.4.2.17. Contractor shall not be financially responsible for Emergency Services when the Primary or Principal Diagnosis is physical in nature regardless of whether procedures are provided to treat a secondary Behavioral Health diagnosis.

10.2.4.3. Residential SUD Services

10.2.4.3.1.1. Residential SUD services: SUD services that provide 24-hour structure, support, and clinical interventions for patients. These services are appropriate for Members 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 Members who need them to establish or maintain their recovery apart from environments that promote continued use in the community.

10.2.4.4. High Intensity Outpatient Services

10.2.4.4.1. Intensive Outpatient Program: Services provided in an outpatient setting and are focused on maintaining and improving functional abilities for a Member through a comprehensive and coordinated individualized and recovery-oriented treatment/service plan, utilizing multiple concurrent services and treatment modalities rendered by a multidisciplinary treatment team lasting a minimum of three hours per day.

10.2.4.4.2. Partial Hospitalization*:* A treatment alternative to a higher level of care (residential and inpatient hospitalization) as a step toward community reintegration. Treatment is comprehensive in a structured, non-residential program of therapeutic activities for a minimum of 20 hours per week in at least four hours but less than 24 hours per day, including associated laboratory services as indicated.

10.2.4.5. Outpatient Services

10.2.4.5.1. Crisis Services are Services provided during a Behavioral Health emergency, which can involve unscheduled, immediate, or special interventions in response to a crisis with a member.

10.2.4.5.1.1. Behavioral Health Secure Transport: Urgent transportation for Members who are experiencing a Behavioral Health crisis and require transportation for Behavioral Health stabilization and treatment, including transportation from community to Provider, and between Provider facilities.

10.2.4.5.1.2. Mobile Crisis Response: The community-based brief intervention, de-escalation, and stabilization of a Member experiencing a Behavioral Health crisis, including follow-up care as defined in 10 CCR 2505-10 8.020.

10.2.4.5.2. Screening and Assessment: Screening is provided to address the needs of those seeking Behavioral Health treatment services in a timely manner. This involves an initial appraisal of a Member's need for services. Assessment Services are the process, both initial and ongoing, of collecting and evaluating information about a Member for developing a profile on which to base treatment/service planning and referral (2 CCR 502-1, 190.1). An assessment may also use a diagnostic tool to gather the information necessary, including services related to Diagnosis, Psychological Testing/Neuropsychological Testing, or Treatment/Service Planning.

10.2.4.5.3. Treatment Services: Treatment services utilize a variety of methods to treat mental, behavioral, and SUDs. The goal is to alleviate emotional disturbances and reverse or change maladaptive patterns of behavior in order to encourage a member's personal growth and development. Treatment can include individual, group, and family psychotherapy, and targeted case management.

10.2.4.5.4. Physician Services: Evaluation and Management (E/M) Services cover a broad range of services for Members in both inpatient and outpatient settings. They are generic in the sense that they are intended to be used by all physicians, nurse- practitioners, and physician assistants and to be used in primary and specialty care alike. These services include medication management, monitoring of medications prescribed, and consultation provided to Members by a physician or other medical practitioner authorized to prescribe medications as defined by state law, including associated laboratory services as indicated.

10.2.4.5.5. Medication-assisted treatment (MAT): Administration and management of Methadone or another approved controlled substance to an opiate dependent Member for the purpose of decreasing or eliminating dependence on opiate substances.

10.2.4.5.5.1. Contractor shall establish a single reimbursement rate for methadone administration (Code H0020) for in-office and take-home doses.

10.2.4.6. Non-State Plan 1915(b)(3) Waiver Services

10.2.4.6.1. Contractor shall provide or arrange for 1915(b)(3) Waiver services to Members in at least the scope, amount, and duration proposed in the State Behavioral Health Services Billing Manual. All 1915(b)(3) services provided to children/youth from ages 0 to 21, except for respite and vocational rehabilitation, are included in the State Plan as EPSDT services.

10.2.4.6.1.1. Mental Health Residential Services – Any type of 24-hour psychiatric care, excluding room and board, provided in a non-hospital, non-nursing home setting. Residential services are appropriate for children, youth, adults, and older adults who need 24-hour supervised care in a therapeutic environment.

10.2.4.6.1.1.1. Crisis Stabilization Units: An agency, endorsed for Behavioral Health crisis and emergency services and that provides short-term, bed-based crisis stabilization services in a 24-hour environment for Members who cannot be served in a less restrictive environment, as defined by 2 CCR 502-1.

10.2.4.6.1.1.2. Acute Treatment Units: An agency or a distinct part of an agency with an endorsement for short-term psychiatric care, which may include treatment for substance use disorders, that provides a 24-hour, therapeutically planned and professionally staffed environment for Members who do not require inpatient hospitalization but need more intense and individualized services than are available on an outpatient basis, such as crisis management and stabilization services, as defined by 2 CCR 502-1.

10.2.4.6.1.1.3. Adult Mental Health Transitional Living Homes: Mental health transitional living homes provide an interim space for Members discharging from an inpatient setting back into community-based care or provide a higher level of care to Members experiencing treatment resistant mental illness to avoid

hospitalization. adult mental health transitional living level 2 homes provide individuals additional structured Behavioral Health intervention and support within a home-like setting providing services including, but not limited to, individual and group therapy, medication management and dispensation, therapeutic services, group activities, and support with activities of daily life including life skill activities and training.

10.2.4.6.2. Intensive Outpatient Services

10.2.4.6.2.1. SUD Partial Hospitalization Program: A treatment alternative to a higher level of care (residential and inpatient hospitalization) as a step toward community reintegration. Treatment is comprehensive in a structured, non- residential program of therapeutic activities lasting more than four hours but less than 24 hours per day, including associated laboratory services as indicated.

10.2.4.6.3. Outpatient Services

10.2.4.6.3.1. Recovery Supports: Recovery-oriented services promote self-management of psychiatric and/or SUD symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports, and rights protection. Services may be provided at schools, churches, or other community locations.

10.2.4.6.3.2. Assertive Community Treatment (ACT): A service delivery model providing comprehensive, individualized, locally-based treatment to adult Members with serious Behavioral Health disorders. ACT services are provided by a multidisciplinary treatment team and are available 24 hours per day, seven days per week, 365 days per year.

10.2.4.6.3.3. Supportive Housing: Services to assist Members in securing and maintaining housing that are therapeutic or skill building in nature and aimed at reducing symptomatology and promoting community integration and social functioning.

10.2.4.6.3.4. Respite Services: Temporary or short-term care of a child, adolescent, or adult provided by adults other than the birth parents, foster parents, adoptive parents, family, or caregivers with whom the Member normally resides, that is designed to give the usual caregivers some time away from the Member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

10.2.4.6.3.5. Behavioral Health Hotline Services: Telephonic Behavioral Health hotline services provided to a Member experiencing a Behavioral Health crisis.

10.2.4.7. Special Coverage for Members Under 21

10.2.4.7.1. Contractor shall provide or arrange for the provision of the following covered services for Members under the age of 21, including unique services available only to children and traditional services that have specific requirements for the treatment of Members under the age of 21:

10.2.4.7.1.1. Inpatient Psychiatric Treatment: A program of care for Members aged 20 and under in which the Member remains 24 hours a day in a psychiatric hospital or other facility licensed as a hospital by the state. Members who are inpatient on their 21st birthday are entitled to receive inpatient benefits until discharged from

the facility or until their 22nd birthday, whichever is earlier, as outlined in 42 CFR § 441.151.

10.2.4.7.1.2. Psychiatric Residential Treatment Facility (PRTF): Psychiatric services for individuals under age 21 provided in a facility that is not a hospital and provides services under the direction of a physician, licensed pursuant to § 12-36-101, C.R.S.

10.2.4.7.1.3. Qualified Residential Treatment Programs (QRTP): Residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

10.2.4.7.1.4. Psychotherapy Services: Autism Spectrum Disorder (ASD) shall be a covered diagnosis for Members under 21 years of age in addition to all other Primary and Principal diagnoses listed in Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses.

10.2.4.7.1.5. Outpatient Services: Contractor shall cover a select set of outpatient services for Members under 21 without a covered diagnosis as listed in Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses.

10.2.4.7.2. Contractor shall be responsible for services provided to justice-involved youth in compliance with the Department's 1115 Waiver.

10.2.4.7.3. Contractor shall provide or arrange for the provision of all Medically Necessary Behavioral Health services for Primary and Principal diagnoses listed in Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses, for children under the age of 21, in accordance with EPSDT, 42 CFR § 441.50 to 441.62 and 10 CCR 2505-10 8.280, and all applicable case law and sub-regulatory guidance.

10.2.4.7.3.1. If a requested EPSDT service is not covered under the capitation, Contractor shall arrange for appropriate services regardless of diagnosis or the Medicaid party responsible for reimbursing the services.

10.2.4.7.4. Contractor shall provide or arrange for the provision of services in accordance with the Child and Youth Medicaid System of Care requirements in Section 11.

10.3. Utilization Management

10.3.1. Contractor shall facilitate seamless access to and actively manage the utilization of covered Behavioral Health services.

10.3.2. Contractor shall provide Covered Services, described in Section 10.2. and Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses, in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

10.3.3. Contractor shall not arbitrarily deny or reduce the amount, scope, or duration of a required service solely because of the diagnosis, type of illness, or condition.

10.3.4. Contractor may place appropriate limits on a service as follows:

10.3.4.1. On the basis of criteria applied under the Medicaid state plan, such as Medical Necessity.

10.3.4.1.1. Contractor shall determine Medical Necessity under EPSDT based on an individualized clinical review of a Member's medical status and in consideration that

the requested treatment can correct or ameliorate a diagnosed health condition, or the service will assist the Member to achieve or maintain maximum functional capacity in performing one or more activities of daily living.

10.3.4.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose and services supporting Members with ongoing or chronic conditions are authorized in a manner that reflects the Member's ongoing needs.

10.3.4.2.1. Contractor shall not apply any financial requirement or treatment limitation to mental health or SUD 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.

10.3.4.2.2. For Members also enrolled in a physical health MCO, Contractor may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or SUD benefits, in any classification, in a manner comparable to and no more stringently than the processes, strategies, evidentiary standards, or other factors applied to the same NQLT in the same benefit classification of the Members medical/surgical benefits.

10.3.5. Contractor shall inform Members, or their families/designated representative(s), 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 families/designated representative(s), are aware of how long the services have been authorized for and therefore may request a continuation of and/or additional services if needed. Contractor shall record and document Contractor's effort to notify Members and families.

10.3.6. Contractor shall develop and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR § 438.905 and 42 CFR § 438.910, that includes, at a minimum, all of the following:

10.3.6.1. Utilization Management Program guidelines that consider the needs of Members.

10.3.6.2. Utilization Management Program and procedures designed and implemented in accordance with standards adopted by accreditation organizations.

10.3.6.3. Periodic review and updates to utilization management guidelines as appropriate.

10.3.6.4. Evidence of a Behavioral Health Provider's involvement in program development and implementation.

10.3.6.5. Description of the Utilization Management Program structure and assignment of responsibility for utilization management activities to appropriate individuals.

10.3.6.6. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

10.3.6.7. Identification of the type of personnel responsible for each level of Utilization Management decision-making.

10.3.6.7.1. Development and implementation of standards for the individual denying a service authorization request or authorizing a service in an amount, duration, or scope that is less than requested, which must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease or by an

individual who has documented a consultation with a health care professional with clinical expertise in treating the Member's condition or disease.

10.3.6.7.1.1. Individuals making Utilization Management decisions for children and youth eligible for the Medicaid System of Care or for admission to a PRTF or QRTP must be specially trained in EPSDT, Colorado's child and youth family System of Care guiding principles, the Medicaid System of Care, Enhanced Standardized Assessment, and the CANS in order to facilitate the child and family-centered model.

10.3.6.7.2. 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.

10.3.6.8. Development and implementation of standards for Utilization Management personnel to consult with the ordering Provider prior to denial or limitation of requested/provided services.

10.3.6.9. Development and implementation of standards to ensure that services supporting beneficiaries with ongoing or chronic health conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports.

10.3.6.10. Clear and specific criteria for discharging Members from treatment.

10.3.6.10.1. Contractor shall include criteria in Member materials and information.

10.3.6.10.2. Contractor shall note individualized criteria for discharge agreed upon by Member and Provider in the Member's health care record and modified, by agreement, as necessary.

10.3.6.11. Policies and procedures for the use and periodic review of written clinical decision-making criteria based on clinical evidence.

10.3.7. Contractor's Utilization Management process shall in no way impede timely access to services.

10.3.8. Contractor shall establish clear procedures for Provider and Members to easily access the utilization management decision-making criteria upon request.

10.3.9. Contractor shall disseminate practice guidelines to all affected Providers and, upon request, Members and potential Members in compliance with 42 CFR § 438.236(c).

10.3.10. Contractor shall provide education and ongoing guidance to Members and Provider about its Utilization Management Program and protocols.

10.3.11. Contractor shall submit written documentation to the Department of any proposed significant changes to Contractor's Utilization Management Program and Procedures at least 30 days in advance of the proposed change going into effect.

10.3.11.1. **DELIVERABLE**: Notice of Proposed Utilization Management Change

10.3.11.2. **DUE**: 30 days in advance of the effective date of proposed change

10.3.12. Contractor shall communicate any changes to clinical review criteria and Contractor's Utilization Management Program and procedures to Network Provider at least 30 days in advance of the changes taking effect.

10.4. PAR Requirements

10.4.1. Contractor shall not require prior authorization for outpatient psychotherapy services.

10.4.2. Contractor shall make determinations regarding prior authorization requests as expeditiously as possible to ensure compliance with the following standards as well as the Notice of Adverse Benefit Determination requirements described in Section 4. These requirements include the following:

10.4.2.1. Standard Authorization: As expeditiously as the Member's health condition requires, but no longer than seven calendar days following Contractor's receipt of the request for service.

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

10.4.2.1.1.1. If Contractor extends the seven day service authorization notice timeframe, Contractor must issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

10.4.2.1.1.2. For requests for treatment in a QRTP or PRTF that require completion of an Enhanced Standardized Assessment, Contractor shall complete a standard authorization no longer than 14 calendar days following Contractor's receipt of the request for service.

10.4.2.2. **PERFORMANCE STANDARD**: 95% of standard PARs will be determined within seven calendar days following Contractor's receipt of the request for service.

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

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

10.4.2.3.2. Authorization of Inpatient and Residential Services, not including Special Connections: As expeditiously as the Member's health condition requires, but no longer than 72 hours following Contractor's receipt of the request for service.

10.4.2.3.3. **PERFORMANCE STANDARD**: 95% of authorization requests for inpatient and residential services not associated with the Special Connections program determined within 72 hours following Contractor's receipt of the request for service.

10.4.2.4. Authorization for Special Connections Program: As expeditiously as the Member's health condition requires, but no longer than 24 hours following Contractor's receipt of the request for service.

10.4.2.4.1. **PERFORMANCE STANDARD**: 95% of authorization requests for the Special Connections program determined within 24 hours following Contractor's receipt of the request for service.

10.4.3. Contractor shall make all reasonable efforts to collect all missing, inadequate, or incomplete information of PARs in order to make determinations within the established timeframes.

10.4.3.1. Contractor shall keep administrative denials of PARs for missing, inadequate, or incomplete information to a minimum.

10.4.3.2. Contractor shall monitor trends and shall have strategies and processes to intervene with a Provider that has an overall PAR denial rate of 10% or higher.

10.4.4. Utilization Management for Inpatient Psychiatric Treatment Services

10.4.4.1. Contractor shall ensure Providers identified as IMDs are utilizing the statewide assessment tool to determine Medical Necessity for residential and inpatient psychiatric treatment services.

10.4.4.2. Contractor shall have processes to monitor the Medical Necessity of treatment in residential and inpatient psychiatric treatment settings for the duration of a member's length of stay until treatment is found to be no longer Medically Necessary.

10.4.4.2.1. Contractor shall continue to assess the Medical Necessity of services provided in a freestanding psychiatric hospital for as long as a Member remains in the facility, including when Contractor is no longer responsible for reimbursing the freestanding psychiatric hospital for a stay that exceeds 60 days.

10.4.5. Utilization Management for SUD services

10.4.5.1. Contractor shall ensure personnel making Utilization Management decisions regarding SUD Covered Services must have completed the ASAM Criteria Utilization Management Course.

10.4.5.1.1. **PERFORMANCE STANDARD**: 100% of Contractor Utilization Management personnel making Utilization Management decisions regarding SUD Covered Services must have completed the ASAM Criteria Utilization Management Course.

10.4.5.2. Contractor shall prior authorize residential and inpatient SUD services except as follows:

10.4.5.2.1. Contractor shall utilize ASAM criteria only to determine Medical Necessity for residential and inpatient SUD treatment services.

10.4.5.2.2. Contractor shall not require prior authorization for admission to a 3.2WM or 3.7WM service. Medical Necessity is required, and Contractor may review the case at any time to determine if Medical Necessity is met, but a Member may not be denied admission because authorization is being reviewed. If Contractor determines that WM was not medically necessary at the time of admission, Contractor may deny payment back to the date of admission.

10.4.5.2.3. Contractor shall perform a continued stay authorization review for all stays longer than five days for a 3.2WM and longer than four days for 3.7WM.

10.4.5.3. When Contractor approves SUD Covered Services, Contractor shall authorize the initial minimum number days of care specified for each of the following SUD service:

10.4.5.3.1. Special Connections Program: 30 days of care.

10.4.5.3.2. ASAM Levels 3.1, 3.3, and 3.5: 14 days of care.

10.4.5.3.3. ASAM Level 3.7: Seven days of care.

10.4.5.3.4. ASAM Level 3.2WM: Five days of care before concurrent authorization.

10.4.5.3.5. ASAM Level 3.7WM: Four days of care before concurrent authorization.

10.4.5.4. Contractor shall have processes to monitor the Medical Necessity of treatment in residential and inpatient SUD facilities for the duration of a member's length of stay until treatment is found to be no longer Medically Necessary.

10.4.5.5. Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

10.4.5.6. Contractor shall participate in Department efforts to implement ASAM 4.

10.4.6. Utilization Management For Members with Co-occurring Disabilities

10.4.6.1. Contractor shall ensure that Members who have co-occurring disabilities have access to necessary Behavioral Health services that are clinically and culturally appropriate. Co-occurring disabilities include, at minimum, all of the following:

10.4.6.1.1. Intellectual or developmental disabilities (I/DD).

10.4.6.1.2. ASD.

10.4.6.1.3. Cognitive impairments.

10.4.6.1.4. Fetal Alcohol Syndrome Disorder.

10.4.6.1.5. Brain injury.

10.4.6.1.6. Physical disabilities.

10.4.6.1.7. People who are deaf, blind, deaf/blind, hard of hearing, and/or other disabilities.

10.4.6.2. Contractor shall make Medical Necessity determinations based on the presence of a covered diagnosis and Contractor's determination that the issues requiring treatment are related to that covered diagnosis.

10.4.6.3. Contractor shall not deny services for a covered diagnosis on the basis that a co-occurring disability is present and there is confusion in determining the etiology of Behavioral Health symptoms.

10.4.6.4. Contractor shall be financially responsible for a Member's treatment when the Member is presenting with Behavioral Health symptoms for the purposes of acute stabilization, safety, and assessment to determine whether or not the Primary Diagnosis occasioning the Member's treatment is a Behavioral Health disorder or a co-occurring disability.

10.4.6.4.1. Contractor shall be financially responsible until a co-occurring disorder diagnosis is determined to be the Primary Diagnosis, at which point Contractor shall no longer be responsible for continued acute stabilization, safety, and assessment services associated with treatment.

10.4.6.5. Any decision to deny services or authorize a service in an amount, duration, or scope that is less than requested to a Member with an intellectual/developmental disability must be

reviewed by an individual competent in the use of the Diagnostic Manual – Intellectual Disability, 2nd Edition (DM-ID-2) as an adaptive diagnostic tool that satisfies the Diagnostic and Statistical Manual of Mental Health Disorders, 5th Edition (DSM-5) criteria.

10.4.6.6. Contractor shall ensure that practitioners use current best practices when assessing for, screening for, and/or diagnosing Behavioral Health conditions in Members who have co-occurring disabilities.

10.4.6.6.1. A co-occurring disability must be present to explain variances from DSM-5 criteria.

10.4.6.7. Contractor shall be financially responsible for treatment for Members with co-occurring disabilities if a covered Behavioral Health diagnosis is in one of the first two positions on a claim.

10.4.6.8. Contractor shall ensure Members with a co-occurring disability have access to the full spectrum of appeal rights for Adverse Benefit Determinations rendered with regard to clinical services for the treatment of a covered Behavioral Health diagnosis.

10.4.7. Utilization Management For Members Under 21

10.4.7.1. Contractor shall ensure that all services, including those provided under EPSDT, are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

10.4.7.1.1. Contractor shall not deny or reduce the amount, duration, and scope of services provided under EPSDT as long as the service is least restrictive and supporting a Member to maintain stability or level of functioning or making treatment progress and is not offered at a lower level of care.

10.4.7.2. Contractor shall use the most current edition of the Statewide Standardized Utilization Management (SSUM) Guidelines or other decision support tool authorized by the Department in conjunction with National Standard Guidelines when making Medical Necessity determinations for Members under the age of 21.

10.4.7.3. Contractor shall incorporate Utilization Management policies and procedures resulting from the Department's work to design and implement the Child and Youth Medicaid System of Care as described in Section 11.

10.4.7.4. Contractor shall approve or deny all requests for QRTP and PRTF services according to the requirements in this section of the Contract, EPSDT, and all applicable federal and state guidelines.

10.4.7.4.1. Contractor shall refer youth for an Enhanced Standardized Assessment to inform their Medical Necessity determination according to 10 CCR 2505-10 8.765.14.A.2 when Contractor is not able to approve QRTP or PRTF services with available clinical information for youth seeking these levels of care.

10.4.7.4.1.1. Contractor shall only use an Enhanced Standardized Assessment for initial authorization purposes. Contractor shall not use an Enhanced Standardized Assessment for continuing authorizations.

10.4.7.4.1.2. Contractor shall issue an administrative denial when an Enhanced Standardized Assessment is cancelled due to a Member's family or guardian not responding to requests for documents within 72 hours.

10.4.7.4.1.3. Contractor shall not pay for an Enhanced Standardized Assessment for which Contractor did not initiate the referral.

10.4.7.4.1.4. Contractor shall accept for consideration an Enhanced Standardized Assessment completed at the request of another payer and dated within 30 Business Days of a request submitted to Contractor for QRTP or PRTF.

10.4.7.4.1.5. Contractor may wait for the Enhanced Standardized Assessment to be completed before placing a youth in a QRTP or PRTF, and then respond to the Enhanced Standardized Assessment findings.

10.4.7.4.2. Contractor shall work with QRTP and PRTF staff to begin discharge planning at admission so there is a discharge plan in place when the Member no longer meets Medical Necessity criteria for continuing authorizations.

10.4.7.4.3. If Contractor denies a request for QRTP or PRTF services due to non-covered diagnosis, Contractor shall refer the youth for an Enhanced Standardized Assessment and pay for the Enhanced Standardized Assessment which is required for QRTP and PRTF services to be covered via Fee-For-Service.

10.4.7.4.3.1. Contractor shall refer the youth for an Enhanced Standardized Assessment within 24 hours of the denial due to non-covered diagnosis.

10.4.7.4.3.2. Contractor shall coordinate the most effective and appropriate level of care for the youth in the least restrictive environment.

10.4.7.4.4. For Members in the custody of child welfare or the Division of Youth Services who are recommended for admission to a QRTP or PRTF, Contractor shall:

10.4.7.4.4.1. Partner with the Department, counties, the Division of Youth Services, BHA, and the BHASOs to ensure Family First Prevention Services Act federal requirements are met related to Member placement in a QRTP and the state policies regarding placement in a PRTF. Contractor shall collaborate with the Department and all parties involved in developing policies and procedures.

10.4.7.4.4.2. Have policies and procedures to ensure Contractor can receive information, at minimum the Enhanced Standardized Assessment, including the CANS, paid for by an entity other than Contractor, to enable Contractor to determine and connect a Member to appropriate treatment.

10.4.7.4.5. Contractor shall report to the Department within five Business Days each instance when Contractor denies QRTP or PRTF level of care based on not meeting Medical Necessity but the Enhanced Standardized Assessment or CANS has recommended QRTP or PRTF level of care.

10.4.7.4.5.1. **DELIVERABLE**: QRTP and PRTF Denial Notification

10.4.7.4.5.2. **DUE**: Within five Business Days of Contractor's sending out a Notice of Adverse Benefit Determination for QRTP or PRTF level of care that that did not match the recommendation from the Enhanced Standardized Assessment or CANS.

10.4.7.4.6. Contractor shall report to the Department within three Business Days of Contractor receiving an Appeal regarding an Adverse Benefit Determination for QRTP or PRTF level of care that did not match the recommendation from the Enhanced Standardized Assessment or CANS.

10.4.7.4.6.1. **DELIVERABLE**: QRTP and PRTF Appeal Notification

10.4.7.4.6.2. **DUE**: Within three Business Days of Contractor receiving an Appeal for an Adverse Benefit Determination that did not match the Enhanced Standardized Assessment or CANS recommendation.

10.4.8. Peer to Peer Consultation

10.4.8.1. Contractor shall provide upon request peer-to-peer consultations that are defined as a process for the Member's ordering or rendering Provider to discuss a denial determination of an authorization with a qualified practitioner who has appropriate expertise in addressing the Member's needs. This review may also include the submission of additional clinical information for review.

10.4.8.2. Contractor shall conduct a peer-to-peer consultation for any Network Provider who is dissatisfied with Contractor's decision on any type of review and who has requested the peer-to-peer consultation after a denial or partial denial decision.

10.4.8.3. Contractor shall offer a peer-to-peer consultation to any Provider regardless of the PAR timeline.

10.4.8.4. Contractor shall review any additional clinical information during the peer-to-peer consultation, if submitted within the first five days following a denial decision.

10.4.9. Notification of Denied Services and Alternative Services

10.4.9.1. If Contractor determines that the Member does not meet standards of Medical Necessity for Behavioral Health services, Contractor shall inform the Member about alternative services and/or level of care that are recommended instead of the requested services and how other appropriate services may be obtained, pursuant to federal Medicaid managed care rules. Contractor shall coordinate within the Medicaid Provider system and the Health Neighborhood to refer the Member to the appropriate Provider, such as CMAs.

10.4.10. Contractor shall not be liable for any Covered Services provided prior to the date a Member is assigned to Contractor under this Contract or after the date of a Member's disenrollment.

10.4.11. Contractor shall not hold a Member liable for Covered Services:

10.4.11.1. Provided to the Member, for which the Department does not pay Contractor.

10.4.11.2. 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.

10.4.11.3. Furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor provided the services directly.

10.4.12. Contractor shall program and design a Utilization Management tracking system to meet data submission guidelines established by the Department.

10.4.12.1. Contractor shall submit Utilization Management Data to the Department or its contractor in a format determined by the Department.

10.4.12.1.1. **DELIVERABLE**: Utilization Management Data

10.4.12.1.2. **DUE**: Monthly, no later than 15 calendar days following the month for which the data covers

10.5. Parity Compliance

10.5.1. Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

10.5.1.1. To meet the requirements of 42 CFR § 440.395, Contractor shall cover, in addition to services covered under the State Plan, any Behavioral Health services necessary for compliance with the requirements for Parity in mental health and SUD benefits in 42 CFR § 438 (k). Identification of services will be contingent upon work done by parity contractor's analysis.

10.5.2. Contractor may not impose NQTLs for mental health or SUD benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD 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.

10.5.2.1. Contractor's pre-authorization requirements shall comply with the requirements for parity in mental health and SUD benefits as described in 42 CFR § 440.395(b)(4).

10.5.2.2. Contractor shall provide to the Department all necessary documentation to show that Behavioral Health services provided through Contractor's delivery system and/or through an external entity are compliant with the Federal parity requirements under 42 CFR 438, subpart K.

10.5.2.3. Contractor shall provide all documentation necessary for determination of Contractor's compliance with Federal parity requirements. Contractor shall provide this documentation upon request for the Department's annual report as required by C.R.S. § 25.5-5-421.

10.5.2.3.1. **DELIVERABLE**: Parity Report Documentation

10.5.2.3.2. **DUE**: Within 21 calendar days after the Department's documentation request

10.6. Providers

10.6.1. Contractor shall require Network Providers to comply with data collection requirements established by the BHA, including all of the following:

10.6.1.1. The use of BHA technology related to inpatient and residential Behavioral Health bed availability and placement.

10.6.1.2. Changes to and compliance with BHA data collection products that track SUD, crisis, and mental health encounter data.

10.6.1.3. Changes to and compliance with the Medication Assisted Treatment Central Registry for Members receiving Medication Assisted Treatment.

10.6.2. Contractor shall not prohibit or restrict a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is the Provider's patient regarding:

10.6.2.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

10.6.2.2. Any information the Member needs to decide among all relevant treatment options.

10.6.2.3. The risks, benefits, and consequences of treatment or non-treatment. The Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and the right to express preferences about future treatment decisions.

10.6.3. Contractor shall use the most current version of the Consolidated Managed Care Entity (MCE) Outpatient Behavioral Health Audit Tool when completing chart reviews of outpatient Behavioral Health Provider.

10.6.4. Out-of-Network Providers

10.6.4.1. If Contractor is unable to provide covered Behavioral Health services to a particular Member within its network, Contractor shall provide the covered services out-of-network at no cost to the Member in accordance with the access to care standards described in Section 5.5.

10.6.4.1.1. Contractor shall coordinate payment with out-of-network Providers and ensure the cost to the Member is no greater than it would be if the services were furnished within Contractor's network

10.6.4.2. Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network Providers for mental health or SUD benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network Providers for medical/surgical benefits in the same classification.

10.6.5. Psychiatric Hospitals

10.6.5.1. Contractor shall maintain a written collaborative agreement with Colorado Mental Health Hospitals and private Freestanding Psychiatric Hospitals. The collaborative agreement shall include, but is not limited to, all of the following:

10.6.5.1.1. The ADA requirement that Members be served in the most integrated setting appropriate to the Member's needs, including the responsibilities of the Members Provider, as applicable, to ensure a seamless transition of care upon admission and discharge to the community.

10.6.5.1.2. Agreements regarding information sharing and collaboration between Contractor and Colorado Mental Health Hospitals and private Freestanding Psychiatric Hospitals.

10.6.5.2. To provide the full continuum of Medically Necessary services covered under the Capitated Behavioral Health Benefit, Contractor shall establish agreements with a statewide network of Colorado Mental Health Hospitals and Free-Standing Psychiatric Hospitals.

10.6.5.3. Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Colorado mental health hospitals to safe and alternative environments. Contractor shall participate in discussions and care coordination with the Colorado mental health hospitals, and Contractor shall have plans in place to provide Medically Necessary Covered Services once the Member has been discharged from the Colorado mental health hospitals.

10.6.5.3.1. Contractor shall work with appropriate treatment Provider in their region in order to transition children from hospitals to safe and alternative step-down environments

such as home and residential facilities. 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.

10.6.6. Contractor shall actively work with ED, residential, and inpatient facilities to ensure Members are discharged in a timely manner. For Members who remain in a facility after the Member is determined ready to discharge, Contractor shall work with the Department to establish benchmarks for transitioning a Member based on setting.

10.6.6.1. Contractor shall work with the Department, BHA, and other relevant state agencies to review cases of Members that have been indicated as posing difficulties for returning back to the community. Contractor shall identify barriers to discharge and develop an appropriate transition plan back to the community.

10.7. Measurement-Based Care

10.7.1. Contractor shall have staff with expertise in the use of measurement-based care for Behavioral Health. Measurement Based Care "involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. Aggregated symptom rating scale data can be used for professional development at the Provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level." (Fortney et. al. 2017).

10.7.2. Contractor shall offer support to Safety Net Providers interested in adopting measurement-based care as part of the Safety Net Providers' clinical practice. Support may include financial assistance, sharing of technology and data solutions, and practice transformation activities.

10.7.3. Contractor shall support interested Safety Net Providers in building a measurement-based care program aligned with best practice and key principles of measurement based care that shall include, at minimum, all of the following:

10.7.3.1. Selection of validated brief symptom rating tools that are validated for frequent measurement and are appropriate for specific populations served.

10.7.3.2. Clinical training and staff readiness.

10.7.3.3. Workflow and operational considerations including:

10.7.3.3.1. Identified frequency of measurement (recommend twice per month and no less than one time per month) aligned with best practice.

10.7.3.3.2. Development of a registry or use of a technology solution to track measurements and clinical progress and support clinician and organizational review of patient and aggregate data.

10.7.3.3.3. Monitor that technology solutions are easy for Members and clinicians to use.

10.7.3.3.4. Monitor that treatment adaptation occurs in response to clinical data.

10.7.3.3.5. Collaborative, data-driven reevaluation of the treatment plan and level of care planning.

10.7.4. Contractor shall partner with Safety Net Providers implementing Measurement Based Care to gather and analyze data and reports to increase treatment efficacy and efficiency.

10.7.4.1. Contractor shall identify, at minimum, all of the following:

10.7.4.1.1. Members experiencing treatment deterioration.

10.7.4.1.2. Members who are not progressing as expected within the Member's treatment plan.

10.7.4.1.3. Providers or programs that need quality improvement and plans for improvement.

10.7.4.1.4. Populations or system-level challenges where the safety net network is demonstrating minimal improvement and where innovation or Contractor engagement may be needed to develop an alternative.

10.7.5. Contractor shall create a Measurement Based Care Report for the Department that describes, at a minimum, all of the following information:

10.7.5.1. Number and names of practices utilizing measurement-based care.

10.7.5.2. Number and names of practices Contractor is working with to adopt measurement-based care, including projected timeline for implementation.

10.7.5.3. Performance of specific measurement-based care metrics.

10.7.5.4. Description of how Contractor is using measurement-based care Outcomes to improve the management of the covered Behavioral Health services and increasing access to appropriate care for Members.

10.7.6. Contractor shall submit the Measurement Based Care Report to the Department for review and approval.

10.7.6.1. **DELIVERABLE**: Measurement Based Care Report

10.7.6.2. **DUE**: Annually, on February 1

10.8. Payments

10.8.1. Contractor shall reimburse Providers for the provision of Covered Services within Contractor's established Utilization Management policies and agreed upon payment arrangements.

10.8.2. Unless otherwise stated in the Work, Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different Providers in the same specialty.

10.8.3. Required Reimbursement Strategies

10.8.3.1. Comprehensive Provider Reimbursement

10.8.3.1.1. Contractor shall reimburse Comprehensive Providers the Department established encounter rate for services identified for allowable costs. The Department reserves the right to change the minimum requirement payment to Comprehensive Providers to align with Behavioral Health safety net reforms in the future.

10.8.3.1.1.1. Contractor shall reimburse each Comprehensive Provider the encounter rate calculated in accordance with Department documented procedures.

10.8.3.1.2. Contractor shall update the Comprehensive Provider encounter rates upon Department notification.

10.8.3.1.2.1. Contractor shall reimburse Comprehensive Providers a prospective payment system payment when a Member utilizes one of a specific set of services, or trigger event, listed in the State Behavioral Health Services Billing Manual. Providers shall be eligible for a maximum of one prospective payment system payment per day, per Member, regardless of how many trigger events were present so long as there was at least one.

10.8.3.1.3. Contractor shall participate in accuracy audits with Comprehensive Providers. Should the Department recognize any discrepancy in Comprehensive Provider payments (less than the full encounter rate), Contractor is responsible for reimbursing the Comprehensive Provider the difference of the encounter payment and the initial reimbursement amount.

10.8.3.1.4. Contractor shall submit the encounter data for Comprehensive Provider visits to the Department per the specifications provided in Section 12.

10.8.3.1.5. Contractor shall negotiate with Comprehensive Providers on reimbursement policy for services not included in the encounter rate, such as services not required of Comprehensive Providers.

10.8.3.1.6. In addition to an encounter rate and other rates for Comprehensive Provider services, Contractor shall offer a complementary value-based purchasing arrangement with Comprehensive Providers to create incentives and financing to support improved quality and to assist in mitigating perverse financial incentives.

10.8.3.1.6.1. Contractor shall design the value-based purchasing arrangements with Comprehensive Providers in accordance with the Department's standardized framework.

10.8.3.1.6.1.1. Contractor shall offer a Value-based Payment arrangement to all in-network Comprehensive Providers located in Contractor's assigned region, to assist the Provider to connect to the state's health information exchange and to begin reporting on social drivers of health screenings using specifications determined by the Department.

10.8.3.1.6.2. Contractor shall design their own unique risk parameters within the Department's standardized framework, including the amount of incentives.

10.8.3.1.6.3. Contractor may implement penalties for not meeting established quality performance metrics.

10.8.3.1.6.4. Contractor shall design the value-based purchasing arrangement utilizing Department identified, statewide quality metrics.

10.8.3.1.7. Contractor shall participate in the Department's accuracy audits process for Comprehensive Providers and is required to complete any necessary documentation upon the Department's request.

10.8.3.2. FQHC and RHC Encounter Reimbursement

10.8.3.2.1. Contractor shall reimburse the FQHC or RHC by at least the encounter rate in accordance with 10 CCR 2505-10 § 8.700.6 and the Medicaid state plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 § 8.700.3 for allowable costs identified in 10 CCR 2505-10 § 8.700.5. The Department reserves the

right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

10.8.3.2.2. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505- 10 § 8.700.6c.

10.8.3.2.2.1. The Department notifies Contractor of the FQHC and RHC encounter rates on a quarterly basis.

10.8.3.2.2.1.1. The Department conducts quarterly accuracy audits with FQHCs and RHCs. Should the Department recognize any discrepancy in FQHC or RHC payments (less than the full encounter rate), Contractor is responsible for reimbursing the FQHC or RHC the difference of the encounter payment and the initial reimbursement amount. FQHC and RHC visits are defined in 10 CCR 2505-10 § 8.700.1.

10.8.3.2.3. If multiple Behavioral Health services are provided by an FQHC or RHC within one visit, Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. Contractor shall pay the FQHC or RHC at minimum the encounter rate.

10.8.3.2.4. Contractor shall submit the encounter data for FQHC and RHC visits to the Department per the specifications provided in Section 12.

10.8.3.2.5. 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.

10.8.3.2.6. 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).

10.8.3.3. Essential Provider Reimbursement

10.8.3.3.1. Contractor shall reimburse Essential Providers in accordance with Department guidance for identified services to promote access to the essential services provided and support quality care.

10.8.3.3.1.1. The Department reserves the right to change the minimum requirement payment to Essential Providers to align with Behavioral Health safety net reforms in the future if required by state or federal regulations.

10.8.3.3.2. Contractor shall submit the encounter data for Essential Provider visits to the Department per the specifications provided in Section 12.

10.8.3.3.3. Contractor shall participate in the Department's accuracy audits process for Essential Providers and is required to complete any necessary documentation upon the Department's request.

10.8.3.4. Directed Payment Fee Schedule

10.8.3.4.1. Contractor shall collaborate with the Department and BHA to identify services that are critical and often challenging to offer to Members as few Providers will accept Contractor's established rate for the service.

10.8.3.4.2. Contractor shall reimburse Network Providers, at a minimum, the rates reflected on the Directed Payment Fee Schedule in the most recently published State Behavioral Health Services Billing Manual.

10.8.3.4.3. Contractor shall collaborate with the Department to develop appropriate processes that enable the Department to monitor the reasonableness of Contractor's reimbursement rates for Network Providers.

10.8.3.5. Physician Incentive Plans

10.8.3.5.1. Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

10.8.3.5.1.1. 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.

10.8.3.5.2. Contractor shall only operate physician incentive plans if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

10.8.3.5.2.1. If Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

10.8.3.5.2.1.1. **DELIVERABLE**: Physician Incentive Plan

10.8.3.5.2.1.2. **DUE**: On the Operational Start or upon implementation of a Physician Incentive Plan

10.8.3.6. Integrated Care

10.8.3.6.1. Contractor shall reimburse identified integrated care practices in accordance with Department-established payment strategies that include coverage of select integrated care codes and Value-Based Payment approaches to support the increase and sustainability of integrated care sites, as well as through Contractor's PCMP Payment Program.

10.9. Third Party Payer Liability

10.9.1. Contractor shall develop and implement systems and procedures to identify potential Third Parties that may be liable for payment of all or part of the costs for providing covered services under this Contract. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying Third Parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

10.9.2. Potential liable Third Parties shall include any of the sources identified in 42 CFR § 433.138 relating to identifying liable Third Parties. Contractor shall coordinate with the Department to provide information to the Department regarding commercial Third Party resources.

10.9.3. In the case of commercial health coverage, Contractor shall notify the Department's Fiscal Agent, by telephone or electronically via the Provider portal of any Third Party Payers,

excluding Medicare, identified by Contractor. If the Third Party Payer is Medicare, Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number electronically via the Fiscal Agent's Provider portal. If the Member has health insurance coverage other than Medicare, Contractor shall submit to the Department's Fiscal Agent the following information:

10.9.3.1. Member's Medicaid identification number.

10.9.3.2. Member's full name.

10.9.3.3. Identification of the health carrier or health plan.

10.9.3.4. Member's health plan identification and group numbers.

10.9.3.5. Policy holder's full name.

10.9.3.5.1. **DELIVERABLE**: Third Party Resource Identification

10.9.3.5.2. **DUE**: Within five Business Days electronically to the Fiscal Agent's Provider portal from the time when the Third Party resource is identified by Contractor.

10.9.3.6. 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.

10.9.3.7. Contractor shall also inform its Members that failure to follow Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that Contractor would have been liable to pay. If Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to Contractor or the Network Provider for payment or cost of the care or services.

10.9.3.8. Contractor shall not restrict access to covered services due to the existence of possible or actual third party liability.

10.9.3.9. 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.

10.9.3.9.1. In the case of accident or casualty coverage, Contractor shall actively pursue and collect from Third Party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by Contractor.

10.9.3.10. In addition to compensation paid to Contractor under the terms of this Contract, Contractor may retain as income all amounts recovered from Third Party resources, up to Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

10.9.3.11. With the exception of Section 14.7.5., and except when directed by the Department or otherwise specified in contracts between Contractor and Network Providers, Contractor shall pay all applicable co- payments, coinsurance and deductibles for approved Covered Services for the Member from the Third Party resource using Medicaid lower-of pricing

methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee- for-Service:

10.9.3.11.1. The sum of reported third party coinsurance and/or deductible or

10.9.3.11.2. Colorado Medicaid allowed rate minus the amount paid by the Third Party, whichever is lower.

10.9.3.12. Contractor shall pay, except as otherwise specified in contracts between Contractor and Network Providers, all applicable copayment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee-for-Service.

10.9.3.13. 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.

10.10. Medical Loss Ratio (MLR)

10.10.1. Contractor shall calculate and report the MLR according to the instructions provided on the MLR template and the guidance provided in 42 CFR § 438.8(a).

10.10.2. The first annual measurement period will begin upon the start of the Operational Period of the Contract and end on June 30, 2026.

10.10.3. 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.

10.10.4. Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

10.10.4.1. Total incurred claims.

10.10.4.2. Expenditures on quality improvement activities.

10.10.4.3. Expenditures related to activities compliant with program integrity requirements.

10.10.4.4. Non-claims costs.

10.10.4.5. Premium revenue.

10.10.4.6. Taxes.

10.10.4.7. Licensing fees

10.10.4.8. Regulatory fees.

10.10.4.9. Methodology(ies) for allocation of expenditures.

10.10.4.10. Any credibility adjustment applied.

10.10.4.11. The calculated MLR.

10.10.4.12. Any remittance owed to the state, if applicable.

10.10.4.13. A comparison of the information reported with the audited financial report.

10.10.4.14. A description of the aggregation method used to calculate total incurred claims.

10.10.4.15. The number of member months.

10.10.4.16. All data provided by Contractor for the purpose of MLR calculation shall use actual costs.

10.10.5. Contractor shall allow for three months claims runout before calculating the MLR. The Department will validate the MLR in accordance with federal guidance.

10.10.5.1. Contractor shall submit the completed MLR calculation on the Department approved template and provide supporting data and documentation per 42 CFR § 438.8(k), including, but not limited to, all encounters, certified financial statements and reporting, and flat files, in compliance with the Department guidelines, for the measurement period by January 15. Contractor shall submit encounter claims in compliance with requirements in Section 12.

10.10.6. Contractor's Medical Spend will be calculated using audited supplemental data provided in Contractor's annual financial reporting and verified using encounter data submitted through flat file submission on a secure server, until such time that the Department deems it appropriate for such Encounter Data submissions to be sent through the interChange.

10.10.6.1. MLR Target: Contractor shall have an MLR of at least 85%. Contractor shall calculate a cohort specific and plan-wide MLR for each SFY using the template provided by the Department.

10.10.6.2. The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR § 438.8(e)) to the denominator (as defined in accordance with 42 CFR § 438.8(f)).

10.10.7. Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

10.10.7.1. Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

10.10.7.2. Contractor shall ensure that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense.

10.10.7.3. Contractor shall ensure that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, are borne solely by the reporting entity and are not apportioned to the other entities.

10.10.7.4. The numerator is the sum of Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's fraud reduction activities.

10.10.7.5. Contractor shall round the MLR to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

10.10.7.6. Contractor shall aggregate data for all Medicaid eligibility groups covered under this Contract.

10.10.8. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse the Department the difference using the following formula:

10.10.8.1. 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).

10.10.8.2. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to Contractor of the amount due, pursuant to 10 CCR 2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

10.10.8.2.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

10.10.9. Subcontracted Claims Adjudication Activities

10.10.9.1. Contractor shall require any subcontractors providing claim adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

10.10.9.2. 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, Contractor shall ensure that all of the following is completed and delivered to the Department for review and approval:

10.10.9.2.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

10.10.9.2.2. Submit a new MLR report meeting the applicable requirements.

10.10.9.2.2.1. **DELIVERABLE**: MLR Calculation Template and supporting data and documentation

10.10.9.2.2.2. **DUE**: Annually, on January 15

10.11. Medicaid Reporting Template

10.11.1. Contractor shall submit an Annual Certified Rate Setting Financial Template that provides a summary of Contractor's financial data for the rate setting cycle, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. The Department will provide the template and an Information Request List (IRL) to Contractor no less than 60 days in advance of the due date.

10.11.2. Contractor shall not modify the Annual Certified Rate Setting Financial Template, unless written approval is provided by the Department, and shall submit supporting data and documentation as outlined in the IRL to provide clarity and detail. The Department may modify the template and will notify Contractor within five business days of the modification.

10.11.3. Contractor shall submit any requested supporting data and documentation to the Department and the designated outside vendor within seven business days after the Department's request.

10.11.4. Contractor shall submit the Annual Certified Rate Setting Financial Template with any requested supporting data and documentation to the Department.

10.11.4.1. **DELIVERABLE**: Annual Certified Rate Setting Financial Template with supporting data and documentation listed in the IRL

10.11.4.2. **DUE**: Annually, by November 15th of each year

10.12. Medicaid Payment in Full

10.12.1. Except as allowed in the Contract, Contractor shall not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf, for Covered Services provided pursuant to this Contract.

10.12.2. Except as allowed in the Contract, Contractor shall ensure that all of its Subcontractors and Network Providers do not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf other than Contractor, for Covered Services provided pursuant to this Contract.

10.12.3. This section shall not be construed to limit the ability of any of Contractor's Subcontractors or Network Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Network Provider and Contractor.

10.12.4. This provision shall survive the termination of this Contract, for authorized services rendered prior to the termination of this Contract, regardless of the reason for the termination. This provision shall be construed to be for the benefit of Contractor's Members.

10.12.5. For fees or premiums charged by Contractor to Members, Contractor may be liable for penalties of up to $25,000.00 or double the amount of the charges, whichever is greater. The Department will deduct from the penalty the amount of overcharge and return it to the affected Members.

10.12.6. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 CFR §§ 95.1 and 95.7, the Department must file all claims for reimbursement of payments to Contractor with CMS within two years after the calendar quarter in which the Department made the expenditure. Contractor and the Department shall work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file Contractor's claims or capitation payments within two years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 CFR § 95.19, no claims or capitations will be paid to Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from Contractor all claims and capitations paid to Contractor for any period of time disallowed by CMS.

10.12.7. Contractor shall meet the requirements of FFS timely payment, per 42 CFR § 447.46. Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities within 20 days after the date of Contractor's receipt of the request for reimbursement. Contractor shall pay 99% of all clean claims from practitioners who are in individual or group practice or who practice in shared

health facilities within 45 days of the date of Contractor's receipt of the request for reimbursement.

10.12.7.1. 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 from 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.

10.12.7.1.1. **PERFORMANCE STANDARD**: 90% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities were paid by Contractor within 20 days after the date of Contractor's receipt of the request for reimbursement.

10.12.7.1.2. **PERFORMANCE STANDARD**: 98% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities were paid by Contractor within 45 days after the date of Contractor's receipt of the request for reimbursement.

10.12.8. Contractor shall ensure that the date of receipt is the date that Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

10.12.8.1. **DELIVERABLE**: Timely Clean Claims Payment Report

10.12.8.2. **DUE**: Quarterly, within 45 days following the end of the quarter for which the report covers

11. CHILD AND YOUTH MEDICAID SYSTEM OF CARE (INTENSIVE BEHAVIORAL HEALTH SERVICES SETTLEMENT AGREEMENT)

11.1. Overview

11.1.1. Contractor shall implement the Department's Child and Youth Medicaid System of Care (MSOC) as a program of the Capitated Behavioral Health Benefit in accordance with this Section and the Department's policies and procedures to be developed in collaboration with the community stakeholders including Contractor and other MCEs.

11.1.2. Contractor shall design its MSOC delivery system consistent with the values and principles of Systems of Care, Intensive Care Coordination such as High-Fidelity Wraparound (HFW), and the *G.A. v. Bimestefer* Settlement Agreement (Settlement Agreement) program design. This includes a commitment to working collaboratively with the Department to ensure that Intensive Behavioral Health Services (IBHS) are delivered in a manner that is family-driven, youth-guided, strengths-based, individualized, community-based, trauma-informed, data-driven, and culturally, disability, and linguistically competent.

11.1.3. Contractor shall design, implement, operate, and monitor the MSOC with, at a minimum, the following principles and approaches in mind:

11.1.3.1. Creating opportunities for family-centered and child-driven preferences to be elicited and prioritized.

11.1.3.2. A collaborative team/inter-agency approach to providing individualized services and supports to Medicaid Members.

11.1.3.3. Creating a delivery model for culturally relevant services and supports in the most integrated, least restrictive setting.

11.1.4. Contractor shall implement the MSOC in compliance with Department guidance on the *G.A. v Bimestefer* Settlement Agreement dated February 20, 2024, the Department's Implementation Plan approved by the plaintiffs, and any subsequent revisions, updates or related court orders.

11.1.4.1. As directed by the Department in writing, Contractor shall incorporate the specific requirements regarding the Settlement Agreement and Implementation Plan into Contractor's overall Behavioral Health service delivery design for children and youth and administration of the Capitated Behavioral Health Benefit. If requirements of Work are identified that are in conflict with the Settlement Agreement or Implementation Plan, Contractor shall modify the Work as necessary to align with the Settlement Agreement or Implementation Plan, subject to prior written approval by the Department. Contractor shall implement any approved changes in compliance with state fiscal and procurement rules including timelines.

11.1.4.2. Contractor shall follow Department guidance regarding a phased implementation of the MSOC that allows time for and supports the appropriate development of the workforce and state infrastructure over time to more effectively meet the needs of the eligible population.

11.1.5. Contractor shall operate the MSOC with the goal of improving the overall well-being of child and youth Members by serving them in their home and community and reducing:

11.1.5.1. Unnecessary emergency department visits,

11.1.5.2. Out-of-home and out-of-state placements,

11.1.5.3. Length of time spent out of the home,

11.1.5.4. Re-entry into higher levels of care, and

11.1.5.5. Involvement in juvenile justice.

11.2. Operational requirements for all MSOC Work

11.2.1. Meeting Requirements and Document Creation

11.2.1.1. Contractor shall participate in Department-led meetings upon Contract Execution regarding the implementation and operationalization of the MSOC in accordance with the Department's guidance on the Settlement Agreement and Implementation Plan.

11.2.1.1.1. Contractor shall ensure the Child and Youth System of Care Manager and other relevant staff participate in the Department meetings to ensure coordinated implementation and standardized operations across the State.

11.2.1.2. During the Start-up Period and throughout the first year of the Work, Contractor shall engage in frequent meetings with the Department and other partners on, at a minimum, the following:

11.2.1.2.1. Establishing the necessary infrastructure to operate the MSOC

11.2.1.2.2. Using best practices to identify eligible children and youth for the MSOC and connect them with services.

11.2.1.2.3. Developing reporting and monitoring tools in alignment with the Implementation Plan's approved quality management strategy.

11.2.1.2.4. Creating and documenting a Department Medicaid System of Care Manual that will address, at a minimum, the following:

11.2.1.2.4.1. Roles and responsibilities.

11.2.1.2.4.2. Provider contracting and oversight.

11.2.1.2.4.3. Collaboration requirements with state entities and state agency intermediaries (e.g., BHA, BHASOs, Workforce Capacity Center)

11.2.1.2.4.4. Utilization Management processes and procedures.

11.2.1.2.4.5. Timely access to care requirements.

11.2.1.2.4.6. Care coordination.

11.2.1.2.4.7. Continuous quality improvement activities.

11.2.1.2.4.8. Monitoring and reporting.

11.2.1.3. Contractor shall collaborate with the Department, stakeholders, and other relevant parties to refine the design and operational implementation of the MSOC to improve the delivery of the full continuum of Behavioral Health services for children and youth ages 0-20.

11.2.1.3.1. Contractor shall partner with the Department and other state partners to implement the 2024 Colorado Child and Youth Behavioral Health Statewide Implementation Plan published by the BHA.

11.2.1.3.2. Contractor shall collaborate with the BHA and BHASOs to improve service access, quality, care coordination, and monitoring and reporting of child and youth Behavioral Health data.

11.2.1.4. Contractor shall establish a MSOC Strategic Plan for implementing the requirements of the Settlement Agreement and Implementation Plan as part of the Capitated Behavioral Health Benefit in accordance with the Medicaid System of Care Manual and Department guidance. The MSOC Strategic Plan shall include specific activities and timeframes and shall address, at minimum, all of the following:

11.2.1.4.1. Member communication and education.

11.2.1.4.2. Network Provider development and oversight.

11.2.1.4.3. Necessary system updates (e.g., claiming).

11.2.1.4.4. Care Coordination.

11.2.1.4.5. Utilization Management.

11.2.1.4.6. Coordination with Workforce Capacity Center.

11.2.1.4.7. Continuity of care.

11.2.1.4.8. Quality management, including required metrics and reporting

11.2.1.5. Contractor shall document and submit its MSOC Strategic Plan to the Department for review and prior approval upon the Department's request. Contractor shall thereafter update its plan at least one time annually for implementing Department-identified

Settlement Agreement and Implementation Plan requirements and submit it to the Department for review and prior approval by July 1 of each year.

11.2.1.5.1. **DELIVERABLE**: Child and Youth Medicaid System of Care Strategic Plan

11.2.1.5.2. **DUE**: Initially upon Department request, then annually by July 1

11.2.2. Member Eligibility for MSOC

11.2.2.1. Contractor shall comply with documented Department guidance regarding the identification of children and youth eligible for the MSOC. Eligibility requirements will evolve over the course of the Contract based on written Department guidance to include more children and youth as the workforce and service availability increases over time and as funding is allocated in the Capitated Behavioral Health Benefit.

11.2.2.2. In accordance with the Settlement Agreement and Implementation Plan, Contractor shall consider the following Members eligible to receive services through the MSOC:

11.2.2.2.1. Children and youth who are under the age of 21 and who have either:

11.2.2.2.1.1. A primary mental health or substance use disorder diagnosis, including Members who may have a co-occurring diagnosis of intellectual and developmental disability; or

11.2.2.2.1.2. A primary intellectual or development disability diagnosis and a co-occurring diagnosis of mental health or substance use disorder.

11.2.2.3. Contractor shall determine a child or youth Member's eligibility for the MSOC based on the following:

11.2.2.3.1. The enhanced Standardized Assessment indicates the need for services in a MSOC level of care for Behavioral Health concerns; and either:

11.2.2.3.1.1. Member's symptoms and behaviors are unmanageable at home, school, or in other community settings without specialized support due to their mental health or SUD condition and are at imminent risk of out-of-home residential care or is at risk of needing PRTF, QRTP, or other long term out-of-home placements; or

11.2.2.3.1.2. Member requires coordination between two or more state-supported systems, including, but not limited to, Juvenile Justice and Child Welfare.

11.2.2.4. Contractor shall not discriminate or exclude children and youth who meet the Department's documented criteria for the MSOC based on a Member's disability or diagnosis.

11.2.3. Administration and Coordination of Full Continuum of Capitated Behavioral Health Treatment Services

11.2.3.1. Contractor shall implement the MSOC in accordance with Department guidance, funding through the Capitated Behavioral Health Benefit, and the State Behavioral Health Services Billing Manual. Treatment services for MSOC shall meet the Settlement Agreement definition for IBHS which means a continuum of Medically Necessary Behavioral Health and support services or interventions, as required and authorized by the Social Security Act, provided in the most integrated setting appropriate to the needs of Medicaid Members, as identified by the Department and as mutually agreed to by the Parties in the Implementation Plan.

11.2.3.2. For children and youth eligible for the MSOC, Contractor shall administer the array of treatment services available through the Capitated Behavioral Health Benefit and required under EPSDT, as well as coordinate services not covered under the Capitated Behavioral Health Benefit but available through Medicaid Fee for Service, EPSDT, and the HCBS Waivers.

11.2.3.3. Contractor shall provide or arrange for all Medically Necessary Behavioral Health services for children and youth under the age of 21 in accordance with the requirements in Section 10: Capitated Behavioral Health Benefit, particularly unique requirements for children and youth, and this Section 11: MSOC.

11.2.3.3.1. If a Member is unable to access an identified service that it is Contractor's responsibility to cover due to Provider capacity or regional limitations, then Contractor shall enter into single case agreements with existing Colorado Medicaid enrolled Providers or recruit additional Providers to ensure Member needs are met. In some cases, Providers may be located out of state.

11.2.3.4. Contractor shall leverage health neighborhood and Care Coordination strategies to collaborate with other child and family serving systems–with particular emphasis on Child Welfare, criminal justice and school-based services.

11.2.3.5. While the Department, BHA, and Contractor work to build the workforce, service capacity, and infrastructure for the delivery of the MSOC, Contractor shall be responsible for:

11.2.3.5.1. Improving the identification and outreach of children and youth eligible for IBHS and Care Coordination.

11.2.3.5.2. Engaging youth and their families in family-centered, team-based Care Coordination.

11.2.3.5.3. Enhancing youth and family access to currently available and Covered Services and supports while monitoring for underutilization of services.

11.2.3.5.4. Collecting and analyzing MSOC data for ongoing improvements in care delivery.

11.3. Capitated Behavioral Health Benefit Covered Services for Phase One of MSOC

11.3.1. For the implementation of phase one of the MSOC that begins July 1, 2025, Contractor shall operate the MSOC with funding included in the Capitated Behavioral Health Benefit for Members between 11 and 17 years of age who meet the following the criteria:

11.3.1.1. Member is eligible for either Enhanced MST or Enhanced FFT in accordance with the fidelity models maintained by MST Services or FFT LLC, and

11.3.1.2. Member is either:

11.3.1.2.1. Anticipated to be discharged from Qualified Residential Treatment Facilities (QRTP), Psychiatric Residential Treatment Facilities (PRTF), or out of state residential treatment facilities within at least the next 60 calendar days, or

11.3.1.2.2. In an Extended Stay or boarding situation as defined by C.R.S. 27-50-101(13.5).

11.3.2. For children and youth not eligible for the first phase of implementation or who choose not to participate in the MSOC, Contractor shall be responsible for coordinating Medicaid-covered and EPSDT services, and providing or arranging for all Medically Necessary Behavioral Health services for children and youth under the age of 21 in accordance with the

requirements in Section 10, Capitated Behavioral Health Benefit, particularly unique requirements for children and youth as identified in Section 10.

11.3.3. Contractor shall comply with Department written guidance and the incorporation of additional funding into the Capitated Behavioral Health Benefit over the course of the Contract to expand the Members eligible for services through the MSOC beyond those Members eligible for the phase one.

11.3.4. Contractor shall provide or arrange for the provision of the following Medically Necessary Covered Services for child and youth Members who meet eligibility requirements for phase one of the MSOC.

11.3.4.1. Enhanced Standardized Assessment: a robust biopsychosocial assessment completed by a certified licensed clinician that includes the Child and Adolescent Needs and Strengths (CANS) tool and gathers a child or youth Member's psychosocial history and presenting concerns to determine diagnoses and baseline level of functioning.

11.3.4.1.1. Contractor shall provide or arrange for an Enhanced Standardized Assessment for all Members meeting the MSOC eligibility requirements for phase one.

11.3.4.1.1.1. At a minimum, Contractor shall have policies and procedures to complete an Enhanced Standardized Assessment prior to a Member's discharge from a QRTP, PRTF, or Extended Stay in an Emergency Department.

11.3.4.1.1.1.1. Contractor shall not be required to provide or arrange for an Enhanced Standardized Assessment if an Enhanced Standardized Assessment has been completed within the past 3 months and the QRTP, PRTF or Enhanced HFW provider has completed ongoing assessment updates utilizing the CANS. Contractor shall ensure that the CANS has been updated prior to discharge in collaboration with the Enhanced HFW provider, QRTP or PRTF provider, family and other members of the treatment team as appropriate.

11.3.4.1.1.1.2. For Members treated in residential treatment facilities located outside of Colorado, Contractor shall ensure an Enhanced Standardized Assessment or updated CANS is completed within 30 calendar days of the Member being discharged back to Colorado.

11.3.4.1.2. Contractor shall ensure the completion of the Enhanced Standardized Assessment by a licensed clinician in accordance with criteria established by the Department and BHA and specified in the State Behavioral Health Services Billing Manual, including but not limited to having current certification for the CANS tool.

11.3.4.1.3. Contractor shall partner with the Department, BHA, and Network Providers to establish timeliness requirements for the completion of an Enhanced Standardized Assessment.

11.3.4.1.4. Contractor shall utilize the results of the Enhanced Standardized Assessment to inform, at a minimum, the following activities:

11.3.4.1.4.1. Authorize treatment services in accordance with the Medically Necessary services recommended by the Enhanced Standardized Assessment and CANS Decision Support Matrix designed for Colorado.

11.3.4.1.4.2. Arrange for Enhanced HFW.

11.3.4.1.4.3. Assist in the development of care plans.

11.3.4.1.4.4. Identify the specific needs of the family.

11.3.4.1.4.5. Establish Contractor's plan to provide Care Coordination support to Members engaged in the MSOC and the Network Providers serving those Members.

11.3.4.1.5. Contractor shall collaborate with the Department, BHA and the Enhanced Standardized Assessment Providers to support the collection and reporting of Enhanced Standardized Assessment and CANS data, level of care determinations from the Enhanced Standardized Assessment and CANS, and any other relevant data.

11.3.4.1.6. At the direction of the Department and with associated funding, Contractor shall provide or arrange for an Enhanced Standardized Assessment for Department-specified populations beyond those Members who initially meet the MSOC eligibility requirements for phase one as described in 11.3.5.

11.3.4.2. Enhanced High Fidelity Wraparound (HFW): an evidence-based model that includes the provision of an intensive coordination process for youth and families experiencing crisis and/or at imminent risk of out-of-home placement. This level of intensity includes services and supports to stabilize and support a youth and their family in their community.

11.3.4.2.1. Contractor shall provide or arrange for Enhanced HFW for children and youth identified through the Enhanced Standardized Assessment process.

11.3.4.2.2. Contractor shall establish contracts with Enhanced HFW Providers in accordance with criteria established by the Department or Workforce Capacity Center and specified in the State Behavioral Health Services Billing Manual.

11.3.4.2.3. Contractor shall have documented policies and procedures to monitor and participate in treatment team meetings for Members residing in a QRTP or PRTF in order to be able to make a referral for Enhanced HFW prior to a Member's anticipated discharge from a QRTP or PRTF and in accordance with the Medicaid System of Care Manual.

11.3.4.2.4. Contractor shall have procedures that support the Enhanced HFW Provider to engage the Member and family and support the completion of the initial treatment team meeting within 30 calendar days of Member placement.

11.3.4.2.5. Contractor shall have documented policies and procedures to monitor that Enhanced HFW Providers offer services as defined in the State Behavioral Health Services Billing Manual and in accordance with requirements established by the BHA, the National Wraparound Implementation Center, and through the Workforce Capacity Center in order to support Members in achieving the best outcomes.

11.3.4.2.5.1. At a minimum, Contractor shall have policies and procedures to monitor whether Enhanced HFW Providers perform the following when delivering services to Contractor's Members:

11.3.4.2.5.1.1. Utilize the CANS tool and Colorado CANS Decision Support Matrix to fidelity for ongoing treatment and service planning as it aligns with HFW.

11.3.4.2.5.1.2. Design Child and Family Centered Plans that include treatment plans describing specific services or level of care determinations based on the CANS.

11.3.4.2.5.1.3. Create and update a Child and Family Centered Plan at least one time every 90 days the child or youth is engaged in Enhanced HFW.

11.3.4.2.5.1.4. Have ongoing contact with the family, Member, and Members of the treatment team as it aligns with HFW.

11.3.5. Intensive home-based treatment through either Enhanced Multisystemic Therapy (MST) or Enhanced Functional Family Therapy (FFT).

11.3.5.1. Contractor shall provide or arrange for Enhanced MST and Enhanced FFT as defined in the State Behavioral Health Services Billing Manual for children and youth Members identified through the Enhanced Standardized Assessment process or Child and Family Centered Plan in order to safely maintain Members in the least restrictive, most normative environment.

11.3.5.1.1. Enhanced MST is an intensive, in-home treatment focusing on factors in an adolescent's (Age 12-17) environment that contribute to their anti-social behavior, including adolescent characteristics, family relations, peer relations, and school performance.

11.3.5.1.2. Enhanced FFT is a systematic, evidence based, manual driven, family-based treatment program used for a wide range of problems (including drug use and abuse, conduct disorder, mental health concerns, truancy, and related family problems) affecting youth ages 11-18 and their families.

11.3.5.2. Contractor shall establish contracts with Enhanced MST and Enhanced FFT Providers in accordance with criteria established by the Department or Workforce Capacity Center and in alignment with requirements in the most recent State Behavioral Health Services Billing Manual.

11.3.6. For Members in phase one, Contractor shall have policies and procedures to deliver both Enhanced HFW and in-home treatment services through either Enhanced MST or Enhanced FFT upon acceptance into the MSOC.

11.3.7. Contractor shall collaborate with the Department, BHA, and Workforce Capacity Center on recruiting and growing a workforce that can meet new state standards for delivery of evidence-based models of Enhanced Standardized Assessment, Enhanced HFW, Enhanced MST, and Enhanced FFT.

11.3.7.1. For SFY 2025-26, Contractor shall Contract with existing Providers of Standardized Assessment which includes the CANS, HFW, MST, and FFT in accordance with Department criteria to provide Enhanced Standardized Assessments, Enhanced HFW, Enhanced MST, and Enhanced FFT. Contractor shall work to support these Providers in complying with new state criteria in order to provide these services in subsequent state Fiscal Years.

11.3.7.2. Contractor shall collaborate with the Department and Workforce Capacity Center to contract with Providers in a timely manner as more Providers begin to meet state criteria for delivery of Enhanced Standardized Assessments, Enhanced HFW, Enhanced MST, and Enhanced FFT.

11.3.8. For counties without sufficient Providers of Enhanced Standardized Assessments, Enhanced HFW, Enhanced MST, or Enhanced FFT, Contractor shall identify and offer alternative

solutions for providing services to achieve the goals of the MSOC. Contractor shall submit reporting on the alternative services provided in a format mutually agreed upon by Contractor and the Department.

11.4. Utilization Management for MSOC

11.4.1. As part of Contractor's Utilization Management program described in Section 10.3 and 10.4, Contractor shall have documented Utilization Management policies and procedures for Members eligible for and participating in the MSOC.

11.4.1.1. In addition to requirements in Section 10.3 and 10.4, Contractor's Utilization Management policies and procedures for the MSOC must reflect the principles for the MSOC and incorporate information from and require the review of all of the following when they exist and are current for a Member and completed according to state requirements:

11.4.1.1.1. Enhanced Standardized Assessment.

11.4.1.1.2. The most recently completed CANS.

11.4.1.1.3. Enhanced HFW Child and Family Centered Plan.

11.4.1.2. Contractor shall make Utilization Management determinations based on, at a minimum, all of the following:

11.4.1.2.1. In accordance with the most current edition of the Statewide Standardized Utilization Management (SSUM) Guidelines or other decision support tool authorized by the Department in conjunction with National Standard Guidelines when making Medical Necessity determinations for Members under the age of 21.

11.4.1.2.2. In accordance with EPSDT and 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, or the service will assist the Member to achieve or maintain maximum functional capacity in performing one or more activities of daily living.

11.4.1.2.2.1. Contractor shall not deny or reduce the amount, duration, and scope of services provided under EPSDT as long as the service is least restrictive and supporting a Member to maintain stability or level of functioning or making treatment progress and is not offered at a lower level of care.

11.4.1.3. Contractor shall partner with the Department and other RAEs to regularly update the Colorado specific CANS Decision Support Matrix and the Identification Tool developed as part of the Enhanced Standardized Assessment to support standardized utilization across regions to inform, at minimum, all of the following:

11.4.1.3.1. Level of care and care planning for children and youth.

11.4.1.3.2. Eligibility for Enhanced HFW interventions.

11.4.1.4. Contractor's Utilization Management Program and Procedures, shall describe, at a minimum, processes to guarantee that individuals making Utilization Management decisions for children and youth eligible for and participating in the MSOC have verifiable knowledge of EPSDT, Colorado's MSOC, Enhanced Standardized Assessment, and CANS-in order to facilitate the child and family-centered model.

11.4.2. Contractor shall establish clear procedures for Providers and Members to easily access the utilization management decision-making criteria upon request.

11.4.3. Contractor shall provide education and ongoing guidance to Members and Providers about its Utilization Management Program and protocols, especially Providers performing the Enhanced Standardized Assessment and delivering Enhanced HFW.

11.4.4. Contractor shall monitor its MSOC Utilization Management policies and procedures on an ongoing basis and evaluate and update Utilization Management program requirements at least annually.

11.4.5. Contractor shall report to the Department within 5 Business Days of distributing a notice of Adverse Benefit Determination for each instance when Contractor denies MSOC services based on not meeting Medical Necessity but the Enhanced Standardized Assessment or CANS has recommended the initially requested MSOC services.

11.4.5.1. **DELIVERABLE**: Medicaid System of Care Denial Notification

11.4.5.2. **DUE**: Within 5 Business Days of Contractor's distributing a notice of Adverse Benefit Determination for MSOC services that did not match the recommendation from the Enhanced Standardized Assessment or CANS.

11.4.6. Contractor shall report to the Department within 3 Business Days of Contractor receiving an Appeal from a MSOC eligible or engaged Member regarding an Adverse Benefit Determination that did not match the recommendations from the Enhanced Standardized Assessment, CANS, or Enhanced HFW Child and Family Centered Plan.

11.4.6.1. **DELIVERABLE**: Medicaid System of Care Appeal Notification

11.4.6.2. **DUE**: Within 3 Business Days of Contractor's receiving an Appeal for an Adverse Benefit Determination that did not match the recommendation from the Enhanced Standardized Assessment, CANS or Enhanced HFW Child and Family Centered Plan.

11.5. Contractor Care Coordination and continuity of care

11.5.1. Contractor shall provide Care Coordination in accordance with the requirements in Section 8 for Tier 3 Care Management for all Members actively participating in the MSOC. Care Coordination activities shall include, at minimum, all of the following:

11.5.1.1. Coordinating the treatment services recommended in the most current Child and Family Centered Plan.

11.5.1.2. Liaising between the Providers, family and treatment team and the RAE Utilization Management, billing and Provider relations teams.

11.5.1.3. Engaging with the Enhanced HFW treatment team/family as a participant of the treatment team, not as the facilitator or primary point of contact.

11.5.2. Contractor shall participate in treatment team meetings facilitated by the Enhanced HFW Provider that may include, at minimum, the RAE Care Coordinator, the Member, family/caregiver, natural supports, treatment providers, and relevant social service, juvenile justice, and/or education entities.

11.5.2.1. For the instances when a Member or family/caregiver chooses to decline Contractor's participation in Enhanced HFW treatment team meetings, Contractor shall follow documented statewide policies and procedures in the Medicaid System of Care Manual

regarding the minimum expectations for how Contractor will engage with the Enhanced HFW Provider on treatment team activities.

11.5.3. When the Enhanced Standardized Assessment or CANS does not indicate the need for Intensive Care Coordination and other MSOC services, Contractor shall continue to offer ongoing Care Coordination for the Member.

11.5.4. Contractor shall support the continued engagement of child and youth Members in the MSOC in accordance with Department requirements and the Medicaid System of Care Manual until such time as the Member transitions out either by:

11.5.4.1. Successfully completing Enhanced HFW.

11.5.4.2. Deciding that they have completed the program and/or they stop participating.

11.5.4.3. Being placed in a higher level of care than the MSOC or is committed to a juvenile detention center.

11.5.5. Following a Member's transition out of the MSOC, Contractor shall provide ongoing Care Coordination in accordance with guidance collaboratively established by the Department and the RAEs in the Medicaid System of Care Manual. At a minimum, Contractor shall offer Tier 3 Care Management for at least 6 months to ensure Members have the necessary supports to maintain stability and well-being in the community and to assist those Members who are discharged from a higher level of care back to the community.

11.5.5.1. For Members who are struggling with maintaining stability in the community, Contractor may be able to authorize the delivery of IBHS services without completing a new Enhanced Standardized Assessment.

11.6. Future Components of MSOC

11.6.1. Upon formal written direction by the Department and in accordance with state and federal statute and regulations, future funding incorporated into the Capitated Behavioral Health Benefit, and written Department guidance, Contractor shall expand the services available and the populations covered under the MSOC.

11.6.2. Contractor shall not be held accountable for performing the activities included in this Section 11.6 without the Department's written notification and without funding being added to the Contract for these activities, unless otherwise required by federal or state statute and regulation. Funding for these activities may be added to the Contract through the actuarially certified rate setting process for the Capitated Behavioral Health Benefit or through the use of an Option Letter.

11.6.3. Contractor shall be prepared to expand the services available under the MSOC upon direction by the Department to include any or all of the following:

11.6.3.1. Identification Tool

11.6.3.1.1. Contractor shall collaborate with the Department and its contracted vendor to create an Identification Tool for the MSOC. The Identification Tool is a brief series of questions aimed at identifying any presence or risk of acute or complex behavioral health needs.

11.6.3.1.2. Once created, Contractor shall use the Identification Tool as part of Contractor's Utilization Management process to identify all the Members that would benefit from receiving the Enhanced Standardized Assessment.

11.6.3.1.3. Contractor shall administer the Identification Tool for Members upon the request of a Member's Provider or a Member's family, caregiver, or guardian.

11.6.3.1.4. Contractor shall track referrals to the Enhanced Standardized Assessment for children and youth identified by the Identification Tool.

11.6.3.2. Intensive Care Coordination (ICC)

11.6.3.2.1. Contractor shall provide or arrange for ICC as defined by the Department for children and youth identified through the Enhanced Standardized Assessment process. ICC is a more intense approach to care planning, coordination of services, authorization of services, and monitoring of services and supports delivered by coordinators with enhanced clinically oriented training.

11.6.3.2.2. Contractor shall establish contracts with ICC Providers in accordance with criteria established by the Department or Workforce Capacity Center and in alignment with requirements in the most recent State Behavioral Health Services Billing Manual to deliver ICC that features, at a minimum, the following National Wraparound Implementation Center models of ICC:

11.6.3.2.2.1. Enhanced HFW

11.6.3.2.2.2. Families experiencing meaningful connections, Outcomes, Coordination, Unconditional Positive Regard, Short-Term Process (FOCUS) for Members who choose not to engage in Enhanced HFW or who are identified through the Enhanced Standardized Assessment to not meet criteria for Enhanced HFW.

11.6.3.2.3. Contractor shall actively participate in ICC established teams that consist of individuals from multiple entities and agencies involved in supporting the Member's successful recovery.

11.6.3.2.4. Contractor shall implement the Child and Family Centered Plans created by the ICC Providers that determine the treatment plan for eligible children and youth. ICC Providers will update the care plans via the CANS at least every 90 days.

11.6.3.2.4.1. Contractor shall authorize Medically Necessary services from the Child and Family Centered Plan and participate in coordination of care for those services when the ICC Provider deems appropriate under the utilization of the CANS and subsequent Decision Support Matrix.

11.6.3.2.4.2. Contractor's Care Coordination team will continue to follow and complement the goals of the Child and Family Centered Plans developed with the team in ICC.

11.6.3.3. Crisis Mobile Response and Resolution Services

11.6.3.3.1. Contractor shall collaborate with the Department and BHA to expand the availability of Crisis Mobile Response and Resolution Services as a means to provide immediate Behavioral Health services, at home or at another safe location, for young people under 21 experiencing significant behavioral or emotional distress.

11.6.3.3.2. Contractor shall leverage the full continuum of crisis services offered by the Colorado Crisis System as a complementary, short-term solution for keeping children from spending longer durations in out-of-home placements and supporting the return of the Member to their home.

11.6.3.3.3. Contractor shall have processes and procedures to support the creation and dissemination of a safety plan to Members in the MSOC. The safety plan should be documented by the IHBT Provider and outline the available resources for crisis services and how to access both the intensive care coordinator and the IHBT Providers during a crisis.

11.6.3.4. Intensive Home-Based Treatment (IHBT)

11.6.3.4.1. Contractor shall provide or arrange for Medically Necessary IHBT as defined by the Department for children and youth identified through the Enhanced Standardized Assessment and CANS. IHBT includes a comprehensive set of therapeutic and rehabilitative services, integrated by a team of Providers into a seamless set of services delivered to the family in the home, school and community where the Member lives. IHBT is delivered with the goal of stabilizing mental health concerns, identifying educational needs and supports, and safely maintaining the youth in the least restrictive, most normative environment.

11.6.3.4.2. Contractor shall establish contracts with IHBT Providers in accordance with criteria established by the Department or Workforce Capacity Center and in alignment with requirements in the most recent State Behavioral Health Services Billing Manual to deliver the models that may include:

11.6.3.4.2.1. Enhanced Multisystemic Therapy (MST).

11.6.3.4.2.2. Enhanced Functional Family Therapy (FFT).

11.6.3.4.2.3. CO-IHBT Model which is a plan for Colorado to build its own intensive in-home treatment model that uses the same evidence-based tenants from other models.

11.6.3.4.2.4. Other evidence-based or evidence-informed practices that are specific to:

11.6.3.4.2.4.1. Children under 8 years of age.

11.6.3.4.2.4.2. Members with intellectual or developmental disabilities.

11.6.3.4.2.4.3. Young adults 18 to 21 years of age.

11.6.3.5. Support Services

11.6.3.5.1. Contractor shall provide or arrange for support services as defined by the Department for children and youth identified through the Standardized Assessment process. Support services are complementary to clinical interventions and are designed to help the Member and their family to successfully engage in treatment and increase the effectiveness of the clinical intervention.

11.6.3.5.2. Contractor shall establish contracts with Providers of support services in accordance with criteria established by the Department or Workforce Capacity Center and in alignment with requirements in the most recent State Behavioral Health Services Billing Manual to deliver models that may include:

11.6.3.5.2.1. Respite services: are services rendered in the member's home, community, or other place of service as a temporary relief from stressful situation/environment.

11.6.3.5.2.2. Therapeutic mentoring: is when a paraprofessional works with a child in their community environment and assists the child in the application of the techniques learned in therapy to real-life settings.

11.6.3.6. Behavioral Management Consultation

11.6.3.6.1. Contractor shall provide or arrange for behavioral management consultation for the IHBT treatment team to utilize the resources and expertise of a behavior specialist via an electronic consultation, in accordance with the most recent State Behavioral Health Services Billing Manual.

11.7. Monitoring and Quality Assurance

11.7.1. Contractor shall facilitate information and data sharing across all treating Providers and have policies and procedures to support the completion of necessary consents and releases of information.

11.7.2. Contractor shall facilitate sharing of information and data that shall include, but is not limited to:

11.7.2.1. Enhanced Standardized Assessments.

11.7.2.2. The CANS tool and CANS Decision Support Matrix from the Enhanced Standardized Assessment and Enhanced HFW interventions.

11.7.2.3. Enhanced HFW care planning.

11.7.2.4. Level of care determinations and changes in level of care determinations.

11.7.3. Contractor shall collaborate with the Department, BHA, and the Workforce Capacity Center to evolve the gathering and monitoring of relevant data to continually improve the state's ability to assess adherence to and support of a child and family-centered care planning process consistent with Enhanced HFW practice and the MSOC principles. The organizations will develop processes and tools that will allow the collection of information that includes, but is not limited to:

11.7.3.1. Enhanced Standardized Assessments.

11.7.3.2. Monitoring the comprehensiveness of the Child and Family-Centered Care Plan needs and goals to ensure that all necessary Enhanced HFW and other Provider services and supports are incorporated into the Child and Family Centered Care Plan.

11.7.3.3. Monitoring alignment between Child and Family-Centered Care Plan needs and goals, and Contractor's service authorizations.

11.7.3.4. Education needs for Enhanced HFW staff regarding the Utilization Management process.

11.7.3.5. Education needs related to Medical Necessity, child and family-centered plans, and appropriate levels of services.

11.7.3.6. Using Provider advisory feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for Providers.

11.7.4. Contractor shall partner with the Department to establish performance metrics for the MSOC that may include the following:

11.7.4.1. Increased capacity within the System of Care

11.7.4.2. Implementation effectiveness, efficiency, cost-effectiveness

11.7.4.3. Quality, timeliness and impact of care

11.7.4.4. Number of children screened for the System of Care

11.7.4.5. Number of children engaged in the System of Care

11.7.4.6. Number of children referred to System of Care interventions

11.7.4.7. Number of children utilizing the System of Care interventions

11.7.4.8. Regional, demographic, and health equity data demonstrating a reduction in disparity

11.7.4.9. Utilization of in-home treatment as compared to residential treatment.

11.7.4.10. Rate of Behavioral Health related emergency department visits

11.7.4.11. Average length of stay in residential treatment

11.7.4.12. Frequency of out-of-state placements

11.7.4.13. Re-entry into higher levels of care such as residential and inpatient.

11.7.4.14. Frequency in which treatment recommendations are incongruent between Contractor and ICC or IHBT Providers.

11.7.5. Contractor shall collaborate with the Department to establish a public dashboard and/or other public reporting mechanism to report performance metrics for the MSOC.

12. DATA ANALYTICS AND CLAIMS PROCESSING SYSTEMS

12.1. Overview

12.1.1. Contractor shall use data and analytics to successfully operate the ACC.

12.1.2. Contractor shall possess the resources and capabilities to leverage existing data systems and analytics tools, including predictive analytics, or create new ones as necessary to perform the Work, conscious to avoid the creation of duplicative systems.

12.1.2.1. Contractor shall use current or historical data to identify opportunities for clinical and Care Coordination interventions to improve quality and cost outcomes.

12.1.3. Contractor shall leverage the Department provided tools and data in conjunction with Contractor's data analytic resources to distribute data to Network Providers and partners in the Health Neighborhood in a manner that makes it easy for Providers to implement interventions that can improve Member health and outcomes, as well as Network Provider performance.

12.1.4. Contractor shall submit all requested data elements to support deliverable and performance standard validation in a format and frequency determined by the Department.

12.1.4.1. **DELIVERABLE**: Data element file(s)

12.1.4.2. **DUE**: To be determined in collaboration with Contractor and Department

12.1.5. Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern, and apply the information to make changes and improve the health of Contractor's Members.

12.2. Department Provided Tools and Resources

12.2.1. Contractor shall use tools provided by the Department, including those currently in development, and other available resources to establish performance benchmarks, monitor Provider performance across key cost and utilization metrics, and support Members in accessing needed care and supports. The existing tools provided by the Department include, but are not limited to, the following:

12.2.1.1. interChange

12.2.1.1.1. Contractor shall maintain an interface that enables Contractor to use the interChange Provider Portal to retrieve eligibility, enrollment and attribution information for Members.

12.2.1.1.1.1. At a minimum, Contractor shall have the capabilities to utilize and process HIPAA standard transactions, such as, but not limited to, the 834 form.

12.2.1.2. Enterprise Data Warehouse

12.2.1.2.1. Contractor shall use the EDW and the Department's specified secure file transfer server to access Member claims, roster reports, and raw data, as well as a variety of custom reports to conduct population health management and support Member Care Coordination.

12.2.1.2.2. Contractor shall leverage custom data feeds including, but not limited to the following, in order to perform the Work:

12.2.1.2.2.1. Weekly vaccine record reports from the Colorado Immunization Information System.

12.2.1.2.2.2. Bimonthly judicial rosters of Members that have recently or will shortly exit the probation system.

12.2.1.2.2.3. Daily Colorado Department of Correction reports of incarcerated persons that may be released within the next 90 days and persons who were released within the past 30 days.

12.2.1.2.2.4. Daily D-SNP admission files from D-SNP Hospitals and Skilled Nursing Facilities.

12.2.1.2.3. Contractor shall have the capacity to share data via MOVEit to the EDW in accordance with agreed upon file specifications and Department security standards. Such data may include Member-level Care Coordination information and utilization management performance,

12.2.1.3. PPQM

12.2.1.3.1. Contractor shall use the PPQM tool to access Contractor's and Network Providers' performance on NCQA-certified Healthcare Effectiveness Data and Information Set (HEDIS) measures and CMS Core Measures derived from Medicaid claims data and other available sources.

12.2.1.3.2. Contractor shall access standard analytics and reports from the PPQM tool, including member and attribution lists, trended Key Performance Indicator data, nationally recognized quality and utilization measures, and cost data.

12.2.1.3.3. Contractor may design queries and searches it requires within the PPQM tool to support Contractor's population health management strategy and interventions.

12.2.1.3.4. Contractor shall support and encourage Network Provider use of the Provider-facing web portal that is part of the PPQM tool. The web portal will provide information on Member rosters, gaps in care reporting, cost data, and Provider performance on ACC-certified HEDIS measures and CMS Core Measures derived from Medicaid claims data and other available sources.

12.2.1.4. 42 CFR Part 2 Data

12.2.1.4.1. The Department will provide Contractor with Part 2 Data for Members enrolled with Contractor, subject to the limitations and requirements contained in this contract provision and 42 CFR Part 2.

12.2.1.4.1.1. Contractor shall only use the Part 2 Data received from the Department for two specific purposes:

12.2.1.4.1.1.1. To assess calculation and payment for performance measures.

12.2.1.4.1.1.2. To provide Care Coordination and/or case management services in support of treatment, payment, or health care operations.

12.2.1.4.1.2. Contractor shall not use the Part 2 Data for any other purpose unless appropriate consent is obtained pursuant to 42 CFR Part 2.

12.2.1.4.1.3. Contractor is fully bound by the provisions of 42 CFR Part 2 upon receipt of the Part 2 Data:

12.2.1.4.1.3.1. Consistent with 42 CFR § 2.32(a)(1), this Part 2 Data will be disclosed to Contractor from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit Contractor from making any further disclosure of information in this record that identifies a patient as having or having had a SUD 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 SUD, except as provided at §§ 2.12(c)(5) and 2.65.

12.2.1.4.1.3.2. Contractor shall implement appropriate safeguards, including written policies and procedures, to prevent unauthorized uses and disclosures of 42 CFR Part 2 data. These policies and procedures shall be documented and reported in Contractor's Data Governance Policy.

12.2.1.4.1.3.3. Contractor shall immediately report any unauthorized uses, disclosures, or breaches of Part 2 Data to the Department.

12.2.1.4.1.3.4. Contractor may only redisclose Part 2 Data to a third party if the third party is a contract agent of Contractor, helping to perform its duties under the Contract, and the contract agent only discloses the information back to Contractor or to the Department.

12.2.2. Additional Data Feeds

12.2.2.1. Contractor shall develop and implement processes to receive and process the following data feeds and to act on the information as expeditiously as possible to address Member needs and improve quality performance.

12.2.2.2. Contractor shall receive direct ADT data feeds from one of Colorado's regional health information exchanges.

12.2.2.3. Contractor shall receive and process the Nurse Advice Line data feed from the Nurse Advice Line contractor.

12.2.2.3.1. Contractor shall distribute information from the Nurse Advice Line to the appropriate Network Provider for follow-up by the Network Provider.

12.2.2.3.2. For Members who were referred to the ED by the Nurse Advice Line but who do not appear to have received follow up care, Contractor shall have policies and procedures to inform the Member's designated PCMP or for Contractor to outreach the Member as timely as possible to assess whether the Member needs care or assistance accessing appropriate care.

12.2.2.4. Contractor shall receive the Inpatient Hospital Transitions data feed from the Department.

12.2.2.5. Colorado Social Health Information Exchange (Co-SHIE)

12.2.2.5.1. Contractor shall participate in and monitor activities for the state design and implementation of the Co-SHIE being developed in collaboration with the Office of eHealth Innovation.

12.2.2.5.2. Contractor shall adopt interoperable technologies as needed to effectively connect to the statewide Co-SHIE for screening, referral, and population health analytics.

12.2.2.5.3. As the Co-SHIE tool is implemented and evolves, Contractor shall participate in Co-SHIE through activities that may include:

12.2.2.5.3.1. Receiving referrals for care coordination and other services,

12.2.2.5.3.2. Sending referrals to community resources and other external partners,

12.2.2.5.3.3. Coordinating care within cross-organizational teams, and

12.2.2.5.3.4. Providing data and analytics to support regional population health analytics in collaboration with state agencies, local public health agencies, and other trusted partners.

12.2.2.6. As the following tools continue to be developed, Contractor shall work with the Department to receive and process data from the following:

12.2.2.6.1. AssureCare Care and Case Management Tool.

12.2.2.6.2. EConsult.

12.2.2.6.3. Prescriber Tool.

12.2.2.6.4. Cost and quality referral indicators.

12.3. RAE Maintained Systems

12.3.1. 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.

12.3.2. Contractor shall ensure that it meets all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 CFR Part 2, 45 CFR § 160, 162 and 164, 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.

12.3.3. Contractor shall control the use or disclosure of PHI as required by the HIPAA BAA, or as required by law. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the HIPAA privacy requirements.

12.3.4. Contractor shall create a data governance policy that describes the circumstances when Contractor shall allow other entities, including Providers and Health Neighborhood organizations, full access to Member level data, including how Behavioral Health data will be shared.

12.3.4.1. Contractor shall update the data governance policy annually and provide it to the Department upon request.

12.3.4.1.1. **DELIVERABLE**: Updated Data Governance Policy

12.3.4.1.2. **DUE**: As requested by Department

12.3.5. Contractor shall integrate select Contractor maintained systems with the Department's Enterprise Solutions Integrator (ESI) after the ESI is fully implemented and operational. Contractor shall collaborate with the Department to ensure integrated systems use standardized data elements.

12.3.6. Care Coordination Tool

12.3.6.1. Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among Members of the Provider Network and Health Neighborhood. Contractor shall make it available for use by small independent Providers and Care Coordinators that have limited or no access to a Care Coordination tool at no cost to those Providers.

12.3.6.2. Contractor shall ensure that the Care Coordination Tool:

12.3.6.2.1. Works on mobile devices.

12.3.6.2.2. Supports HIPAA and 42 CFR Part 2 compliant data sharing.

12.3.6.2.3. Provides role-based access to Providers and care coordinators.

12.3.6.3. Contractor shall ensure the Care Coordination Tool can collect and aggregate, at a minimum, the following information:

12.3.6.3.1. Name and Medicaid ID of Member for whom Care Coordination interventions were provided.

12.3.6.3.2. Age.

12.3.6.3.3. Gender identity.

12.3.6.3.4. Race/ethnicity.

12.3.6.3.5. Name of entity or entities providing Care Coordination, including the Member's choice of lead care coordinator if there are multiple coordinators.

12.3.6.3.6. Care Coordination notes, activities and Member needs.

12.3.6.3.7. Stratification level.

12.3.6.4. Contractor shall ensure that its Care Coordination Tool has the capacity to capture information that can aid in the creation and monitoring of a care plan for the Member, such as clinical history, medications, social supports, resources for health-related social needs, and Member goals.

12.3.6.5. Contractor shall collect and be able to report to the Department the information from the Care Coordination Tool for all Network Providers utilizing the Care Coordination Tool. Although Network Providers and subcontracted Care Coordinators may use their own data collection tools, Contractor shall require them to collect and report on similar or identical data fields.

12.3.6.6. Contractor shall work with the Department to plan for how the Care Coordination Tool can exchange data with other Department tools such as the EDW and the LTSS Case Management system.

12.3.7. Telemedicine Supports for Members

12.3.7.1. Contractor shall support Member use of existing telemedicine technology.

12.3.7.2. Contractor shall possess and maintain a telemedicine option for Members to ensure all Members have access to telemedicine supports.

12.3.7.3. Contractor shall inform members of telehealth options available to them. Contractor shall target communications to Members in Rural Counties and Counties with Extreme Access Considerations and Members attributed to PCMPs that do not have their own telemedicine technology supports.

12.3.8. Claims Processing System for Capitated Behavioral Health Benefit

12.3.8.1. Contractor shall maintain a claims processing system to reimburse Providers for covered services under the Capitated Behavioral Health Benefit and produce encounter claims.

12.3.8.2. Contractor shall ensure that its claims processing has the capability to process claims using the billing procedure codes specified in the State Behavioral Health Services Billing Manual. The State Behavioral Health Services Billing Manual can be found on the Department's website.

12.3.8.2.1. Contractor shall resolve any identified claims processing systems errors as expeditiously as possible, but no longer than 30 days from the date the error is identified.

12.3.8.2.1.1. **PERFORMANCE STANDARD**: Contractor's claims processing system shall comply with quarterly updates to the State Behavioral Health Services Billing Manual within 30 calendar days from the start of the quarter in which the Billing

Manual update is effective or 60 calendar days from when final changes are made available to Contractor, whichever is later.

12.3.8.2.1.2. **PERFORMANCE STANDARD**: 95% of claims processing system errors identified by Contractor, Department, or Network Provider are fixed within 30 calendar days of Contractor identifying or being informed of the claims processing system error, with an additional 15 calendar days for claims reprocessing.

12.3.8.3. Behavioral Health Encounter Data Reporting through interChange

12.3.8.3.1. Contractor shall submit all Encounter Data on all State Plan and 1915(b)(3) Waiver services included within the Capitated Behavioral Health Benefit electronically, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

12.3.8.3.2. Contractor shall submit Encounter Data in the ANSI ASC X12N 837 format directly to the Department's Fiscal Agent using the Department's data transfer protocol. Contractor shall submit any 837 format encounter claims, reflecting paid, adjusted or denied by Contractor, via a regular monthly batch process. Contractor shall submit all encounter claims in accordance with the following:

12.3.8.3.2.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

12.3.8.3.2.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

12.3.8.3.2.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

12.3.8.3.3. Contractor shall submit 95% of all clean encounter claims within 30 days after the month the claim was paid or denied, and 98% of all clean encounter claims within 120 days after the month the claim was paid or denied, following the methodology as agreed upon by the Department and MCEs. Contractor shall submit paid and denied clean Encounter Data into the MMIS each month. The Department will measure performance on a monthly basis.

12.3.8.3.3.1. **PERFORMANCE STANDARD**: 95% of all clean encounter claims were submitted no later than 30 days following the month claim was paid or denied.

12.3.8.3.3.2. **PERFORMANCE STANDARD**: 98% of clean encounter claims were submitted no later than 120 days following the month claim was paid or denied.

12.3.8.3.4. Contractor shall make an adjustment to encounter claims when Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If the Department discovers errors or a conflict with a previously adjudicated encounter claim, Contractor shall adjust or void the encounter claim within 14 calendar days of notification by the Department.

12.3.8.3.5. Contractor shall meet or exceed a 98% reported clean encounter claims acceptance rate for the measurement quarter, following the methodology as agreed upon by the

Department and MCEs. The Department will measure performance on a quarterly basis. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation. At the discretion of the Department, or at the request of Contractor, the accuracy rate may be adjusted to account for Department system changes. Contractor shall develop and implement a plan to meet this standard.

12.3.8.3.5.1. **PERFORMANCE STANDARD**: 98% of Contractor's submitted clean encounter claims are accepted for the measurement quarter. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

12.3.8.3.5.2. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed-upon performance target for SFY 2026-27 for the percent of submitted encounters that are determined by the Department's system to be accurately adjudicated, with the goal that by SFY 2027-28 the target is no less than 98%.

12.3.8.3.6. Contractor shall submit all necessary Encounter Data, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR § 438.242.

12.3.8.3.6.1. Contractor shall submit monthly data certifications for all Encounter Data used for rate setting, in compliance with 42 CFR § 438.604 and 438.606. Contractor shall ensure that the data certification includes certification that data submitted is accurate, complete and truthful, and that all paid encounters are for Covered Services provided to or for enrolled Members.

12.3.8.3.6.1.1. **DELIVERABLE**: Certified Encounter Data submission

12.3.8.3.6.1.2. **DUE**: Monthly, on the last Business Day of the month

12.3.8.3.7. Contractor shall submit its raw Encounter Data, excluding data protected by 42 CFR Part 2, to the Colorado All-Payer Claims Database 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.

12.3.8.3.8. Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change format requirements following consultation with Contractor and retains the right to make the final decision regarding data format submission requirements. Contractor shall have a maximum of 90 days from written communication from the Department to comply with any changes in Department data format submission requirements.

12.3.8.3.9. Contractor shall use enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. Contractor shall ensure that the data transmissions and enrollment reports shall include:

12.3.8.3.9.1. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction.

12.3.8.3.9.2. HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction.

12.3.8.3.9.3. HIPAA X12N 834 Daily Roster.

12.3.8.3.9.4. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

12.3.8.3.9.5. interChange Encounter Reconciliation Report.

12.3.9. Flat File Submission

12.3.9.1. Quarterly, Contractor shall electronically submit a flat file table that contains all encounters for that State Fiscal Year, with one record per encounter, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

12.3.9.1.1. The Department shall provide Contractor with the specifications for the flat file submission.

12.3.9.1.2. The Department shall conduct a quality review of the submission to determine if the flat file meets the required specifications.

12.3.9.1.2.1. **DELIVERABLE**: Certified Quarterly Flat File

12.3.9.1.2.2. **DUE**: Quarterly, on the 10th day of the month following the close of a State Fiscal Quarter.

12.3.9.2. Contractor shall submit a flat file that contains 95% of paid claim lines in the quarter the claims were paid by the Deliverable due date.

12.3.9.2.1. Contractor shall submit a flat file that contains 100% of paid claim lines with the following quarter's submission.

12.3.9.3. Contractor shall be responsible for the accuracy of flat file submissions.

12.3.9.4. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

12.3.10. Annual Submission

12.3.10.1. Contractor shall on an annual basis electronically submit a flat file and data certification certifying the flat file is as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer or Chief Financial Officer or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

12.3.10.1.1. The Department will provide Contractor with the specifications for the annual flat file submission.

12.3.10.1.2. The Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

12.3.10.1.2.1. **DELIVERABLE**: Certified Annual Flat File

12.3.10.1.2.2. **DUE**: Annually, by October 31

12.4. Contractor shall notify the Department at least 90 days in advance of any Contractually required system that Contractor will be transitioning to a different or new system implementation.

12.5. Interoperability Rule

12.5.1. Contractor shall implement the full scope of the Interoperability Rule aligning with the Department's implementation timeline. This shall include at minimum, the following capabilities:

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

12.5.1.2. Include complete and accurate Provider directory information.

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

12.5.1.2.2. The Provider directory information shall be updated no later than 30 calendar days after the Department or Contractor receives the Provider directory information or updates to Provider directory information.

12.5.1.3. Comply with the requirements of 42 CFR § 438.242, § 431.60, 45 CFR § 170.213, and § 170.215, as well as the Provider directory information specified in § 438.10.

12.5.1.4. Provide current Members, or Member representatives, with access to claims and encounter data within one Business Day of receipt, including:

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

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

12.5.1.4.3. Services and Items Provided in Treatment.

12.5.1.4.4. Information about prior authorization requests and decisions (excluding drugs).

12.5.1.4.4.1. This information must be accessible no later than one Business Day after the request is received, be updated no later than one Business Day after any status change and must continue to be accessible for the duration that the authorization is active and at least one year after the prior authorization's last status change.

12.5.1.4.4.2. The information must include all of the following:

12.5.1.4.4.2.1. The prior authorization status.

12.5.1.4.4.2.2. The date the prior authorization was approved or denied.

12.5.1.4.4.2.3. The date or circumstances under which the prior authorization ends

12.5.1.4.4.2.4. The items and services approved.

12.5.1.4.4.2.5. If denied, a specific reason why the request was denied.

12.5.1.4.4.2.6. Related structured administrative and clinical documentation submitted by provider.

12.5.1.5. Clinical information within one Business Day of receipt, if collected and maintained by Contractor, including:

12.5.1.5.1. Diagnoses and Related Codes.

12.5.1.5.2. Medical Records and Reports.

12.5.1.5.3. Laboratory Test Results.

12.5.1.6. Information about covered outpatient drugs within one Business Day after the effective date of any update, including:

12.5.1.6.1. Formulary of prescription drugs and costs to the member

12.5.1.6.2. Preferred drug list information

12.5.2. Contractor shall comply with the requirements of 42 CFR § 438.62 by developing and maintaining a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

12.5.3. Contractor shall incorporate the USCDI standards for data classes and elements received from other plans about the member.

12.5.4. Contractor shall, upon request by a Member:

12.5.4.1. Incorporate into its records Member data with a date of service on or after January 1, 2016, from any other payer that has provided coverage to the Member within the preceding five years.

12.5.4.2. Send all such data to any other payer that currently covers the member, or a payer that the member specifically requests to receive the data classes and elements included in the USCDI content standards, any time during a member's enrollment with Contractor and up to five years after disenrollment.

12.5.5. Contractor shall annually report metrics in the form of aggregated, de-identified data for the previous calendar year to CMS about patient use of the Patient Access API. This will include:

12.5.5.1. The total number of unique patients whose data are transferred via the Patient Access API to a health app designated by the Member; and

12.5.5.2. The total number of unique Members whose data are transferred more than once via the Patient Access API to a health app designated by the Member.

12.5.6. Contractor shall annually report metrics relating to prior authorization, excluding drugs. Contractor shall make the following data from the previous calendar year publicly accessible by posting them on its website:

12.5.6.1. A list of all items and services that require prior authorization.

12.5.6.2. The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

12.5.6.3. The percentage of standard prior authorization requests that were denied, aggregated for all items and services.

12.5.6.4. The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.

12.5.6.5. The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.

12.5.6.6. The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

12.5.6.7. The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

12.5.6.8. The average and median time that elapsed between the submission of a request and a determination by Contractor, for standard prior authorizations, aggregated for all items and services.

12.5.6.9. The average and median time that elapsed between the submission of a request and a decision by Contractor for expedited prior authorizations, aggregated for all items and services.

12.5.7. Contractor shall implement a Prior Authorization API that:

12.5.7.1. Is populated with Contractor's list of covered items and services (excluding drugs) that require prior authorization.

12.5.7.2. Can identify all documentation required by Contractor for approval of any items or services that require prior authorization.

12.5.7.3. Supports a HIPAA-compliant prior authorization request and response, as described in 45 CFR part 162; and

12.5.7.4. Communicates the following information about prior authorization requests:

12.5.7.4.1. Whether Contractor:

12.5.7.4.1.1. Approves the prior authorization request (and the date or circumstance under which the authorization ends).

12.5.7.4.1.2. Denies the prior authorization request; or

12.5.7.4.1.3. Requests more information.

12.5.7.4.1.4. If Contractor denies the prior authorization request, it must include a specific reason for the denial.

12.5.8. Contractor shall implement Prior Authorization processes that include:

12.5.8.1. Contractor shall for standard authorization decisions, provide notice as expeditiously as the Member's condition requires, and

12.5.8.2. On or after January 1, 2026, may not exceed seven calendar days after receiving the request for service.

12.5.8.3. Standard authorization decisions may have an extension of up to 14 additional calendar days if:

12.5.8.3.1. The enrollee or the provider requests the extension; or

12.5.8.3.2. Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the enrollee's interest.

12.5.8.4. For cases in which a Provider indicates, or Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited

authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for service.

12.5.9. Contractor shall implement a Provider Access API that:

12.5.9.1. Makes interoperability data with a date of service on or after January 1, 2016, excluding Provider remittances and Member cost-sharing information, that are maintained by Contractor available to enrolled providers via the API no later than 1 Business Day after receiving a request from such a Provider, if all the following conditions are met:

12.5.9.1.1. Contractor authenticates the identity of the Provider that requests access and attributes the Member to the Provider under the attribution process.

12.5.9.1.1.1. In order to facilitate this, Contractor shall establish and maintain a process to associate Members with their enrolled Providers to enable data exchange via the Provider Access API.

12.5.9.1.2. The Member does not opt out.

12.5.9.1.3. Disclosure of the data is not prohibited by other applicable law.

12.5.9.2. Contractor shall establish and maintain a process to allow a Member or the Member's representative to opt out of the data exchange and to change their permission at any time.

12.5.9.2.1. That process must be available before the first date on which Contractor makes Member information available via the Provider Access API and at any time while the Member is enrolled.

12.5.9.3. Contractor shall provide information to Members in plain language about the benefits of API data exchange with their Providers, their opt out rights, and instructions both for opting out of data exchange and for subsequently opting in, as follows:

12.5.9.3.1. Before the first date on which Contractor makes Member information available through the Provider Access API.

12.5.9.3.2. No later than 1 week after enrollment.

12.5.9.3.3. At least annually.

12.5.9.3.4. In an easily accessible location on its public website.

12.5.9.4. Contractor shall provide on its website and through other appropriate Provider communications, information in plain language explaining the process for requesting Member data using the Provider Access API.

12.5.9.4.1. The resources must include information about how to use the attribution process to associate Members with their Providers.

12.5.10. Contractor shall implement a payer-to-payer API that meets the following criteria:

12.5.10.1. Contractor shall establish and maintain a process to allow a Member or the Member's representative to opt out of the payer-to-payer data exchange and to change their permission at any time.

12.5.10.2. The opt in process shall be offered as follows:

12.5.10.2.1. To current Members, no later than the compliance date.

12.5.10.2.2. To new Members, no later than 1 week after enrollment.

12.5.10.2.3. If a Member has coverage through any Medicaid MCO, PIHP, or prepaid ambulatory health plan (PAHP) within Colorado while enrolled in Medicaid, Contractor must share their opt in permission with those MCO, PIHP, or PAHP to allow the payer-to-payer API data exchange described in this section.

12.5.10.2.4. If a Member does not respond or additional information is necessary, Contractor must make reasonable efforts to engage with the Member to collect this information.

12.5.10.3. Identifies previous and concurrent payers, by establishing and maintaining a process to identify a new Member's previous and concurrent payer(s) to facilitate the payer-to-payer API data exchange. The information request process must start as follows:

12.5.10.3.1. For current Members, no later than the compliance date of January 1, 2027.

12.5.10.3.2. For new Members, no later than 1 week after enrollment.

12.5.10.3.3. If a Member does not respond or additional information is necessary, Contractor must make reasonable efforts to engage with the Member to collect this information.

12.5.10.4. The data in the payer-to-payer exchange shall include:

12.5.10.4.1. Data specified in 42 CFR § 431.60(b), with a date of service within five years before the request, excluding the following:

12.5.10.4.1.1. Provider remittances and enrollee cost-sharing information.

12.5.10.4.1.2. Denied prior authorizations.

12.5.10.4.1.3. Any unstructured administrative and clinical documentation submitted by a Provider related to prior authorizations.

12.5.10.5. Contractor must request the data through the Member's previous payers' API, if all the following conditions are met:

12.5.10.5.1. The beneficiary has opted in, except for data exchanges between the Department and its contracted MCOs, PIHPs, or PAHPs, which do not require a Member to opt in.

12.5.10.5.2. The exchange is not prohibited by other applicable law.

12.5.10.6. Contractor must include an attestation with this request affirming that the Member is enrolled with Contractor and has opted into the data exchange.

12.5.10.6.1. Contractor must complete this request as follows:

12.5.10.6.1.1. No later than 1 week after the payer has sufficient identifying information about previous payers and the Member has opted in.

12.5.10.6.1.2. At a beneficiary's request, within one week of the request.

12.5.10.7. Contractor must receive through this API and incorporate into its records about the Member, any data made available by other payers in response to the request.

12.5.10.8. Concurrent coverage data exchange.

12.5.10.8.1. When a Member has provided sufficient identifying information about concurrent payers, Contractor shall:

12.5.10.8.1.1. Request the Member's data from all known concurrent payers and at least quarterly thereafter while the Member is enrolled with both payers.

12.5.10.8.1.2. Respond within one Business Day of a request from any concurrent payers. If agreed upon with the requesting payer, Contractor may exclude any data that were previously sent to or originally received from the concurrent payer.

12.5.10.9. Contractor shall provide Members educational resources. This includes providing information to applicants or Members in plain language, explaining at a minimum:

12.5.10.9.1. The benefits of payer-to-payer API data exchange, their ability to opt in or withdraw that permission, and instructions for doing so. This must be provided:

12.5.10.9.1.1. When requesting a Member's permission for payer-to-payer API data exchange.

12.5.10.9.1.2. At least annually, in appropriate mechanisms through which Contractor ordinarily communicates with current beneficiaries.

12.5.10.9.1.3. In an easily accessible location on its public website.

13. OUTCOMES, QUALITY ASSESSMENT, AND PERFORMANCE IMPROVEMENT PROGRAM

13.1. Overview

13.1.1. Contractor shall use data and analytics as part of its continuous quality improvement strategy for the full range of management, coordination, and care activities, including, but not limited to, process improvement, population health management, federal compliance with federal regulations, claims processing, outcomes tracking and cost control.

13.1.1.1. Contractor shall analyze the key cost drivers within Contractor's region and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

13.1.1.2. Contractor shall report Contractor's findings to the Department in a timely manner, this may be using an appropriate existing Deliverable, such as the Contracted Network Management Strategic Plan; through an appropriate meeting with the Department, such as the Quarterly Leadership Meeting; or through an ad hoc communication vehicle.

13.1.1.3. Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

13.1.2. Contractor shall implement and maintain an ongoing comprehensive quality assessment and performance improvement program (Quality Improvement Program) that complies with 42 CFR § 438.310-370.

13.1.3. Contractor shall take into consideration the federal definition of quality when designing its program. CMS defines quality as the degree to which Contractor increases the likelihood of desired outcomes of the 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.

13.1.4. Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the PCCM Entity and PIHP.

13.2. Quality Improvement Program

13.2.1. 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 all of the following:

13.2.1.1. Performance improvement projects.

13.2.1.2. Collection and submission of performance measurement data, including Member experience of care.

13.2.1.3. Mechanisms to detect both underutilization and overutilization of services.

13.2.1.4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department.

13.2.1.5. Quality of care grievances.

13.2.1.6. External Quality Review.

13.2.1.7. Advisory committees and learning collaboratives.

13.2.2. Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how Contractor plans to implement its Quality Improvement Program. Contractor shall make reasonable changes to the Quality Improvement Plan at the Department's direction.

13.2.2.1. **DELIVERABLE**: Quality Improvement Plan

13.2.2.2. **DUE**: July 1, 2025

13.2.3. Contractor shall submit an Annual Quality Report to the Department and/or designee, providing updates to Contractor's Quality Improvement Plan and detailing the progress and effectiveness of each component of its Quality Improvement Program. Contractor shall include at minimum, all of the following in the report:

13.2.3.1. A description of the techniques Contractor used to improve its performance.

13.2.3.2. A description of the qualitative and quantitative impact the techniques had on quality.

13.2.3.3. The status and results of each Performance Improvement Project conducted during the year.

13.2.3.4. Lessons learned.

13.2.3.5. Opportunities for improvement.

13.2.3.6. Updates to the Quality Improvement Plan

13.2.3.6.1. **DELIVERABLE**: Annual Quality Report

13.2.3.6.2. **DUE**: Annually, no later than the last Business Day in September beginning in 2026.

13.2.3.7. Contractor shall publicly post its Annual Quality Report.

13.3. Performance Improvement Projects

13.3.1. Contractor shall conduct Performance Improvement Projects designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

13.3.2. Contractor shall complete Performance Improvement Projects on a multiyear cycle, including annual reporting, to facilitate the integration of project findings and information into the overall quality assessment and improvement program, and to produce new information on quality of care each year.

13.3.3. Contractor shall have a minimum of two Behavioral Health Performance Improvement Projects chosen in collaboration with the Department that include at minimum, all of the following: one clinical project that may include physical health integration into Behavioral Health and one non-clinical project.

13.3.3.1. Contractor shall conduct Performance Improvement Projects on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a particular topic.

13.3.4. Contractor shall have the capacity to conduct up to two additional Performance Improvement Projects upon request from the Department.

13.3.5. Contractor shall ensure that Performance Improvement Projects include the following:

13.3.5.1. Measurement of performance using objective quality indicators.

13.3.5.2. Implementation of system interventions to achieve improvement in quality.

13.3.5.3. Evaluation of the effectiveness of the interventions.

13.3.5.4. Planning and initiation of activities for increasing or sustaining improvement.

13.3.6. Contractor shall participate in a Performance Improvement Project learning collaborative at the end of each Performance Improvement Project cycle hosted by the Department that includes sharing of data, outcomes, and interventions.

13.3.7. Contractor shall submit Performance Improvement Projects for validation by the Department's External Quality Review Organization (EQRO) to determine compliance with requirements set forth in 42 CFR § 438.350, and as outlined in External Quality Review Organization Protocol for Validating Performance Improvement Projects document. These requirements include:

13.3.7.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction.

13.3.7.2. Measurement of performance using objective valid and reliable quality indicators.

13.3.7.3. Implementation of system interventions to achieve improvement in quality.

13.3.7.4. Empirical evaluation of the effectiveness of the interventions.

13.3.7.5. Planning and initiation of activities for increasing or sustaining improvements.

13.3.8. Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report.

13.4. Performance Measurement

13.4.1. 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.

13.4.2. Contractor shall consult with the Department to develop measurement criteria, reporting frequency and other performance measurement components. The Department will determine the final measurement and pay for performance criteria.

13.4.3. Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

13.4.4. Contractor shall provide data, as requested, to enable the Department or its designee to calculate the performance measures, unless the data is already in the Department's possession.

13.4.5. Contractor shall support Network Providers and care coordinators to collect and report information required to calculate the performance measures.

13.4.6. Contractor shall track their performance on identified measures monthly through the PPQM and other data resources as appropriate.

13.4.7. Contractor shall provide comments regarding any or all of the Department's documented calculation methodologies for pay for performance measures.

13.4.8. Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

13.4.9. Contractor shall collect at the request of the Department information from Network Providers necessary to supplement the calculation of CMS Adult and Child Core Measure sets.

13.4.10. Contractor shall have a strategy for supporting Network Providers in achieving the national average performance on the CMS Adult and Child Core Measure sets.

13.4.11. ACC Pay for Performance

13.4.11.1. Contractor shall participate in at minimum of three components of pay for performance.

13.4.11.1.1. Key Performance Indicators (KPIs):

13.4.11.1.1.1. Contractor shall be capable of working to improve performance on KPIs to enable both Contractor and Network Providers to earn performance payments. Contractor shall support Network Providers in achieving practice-specific targets for KPIs, as well as work comprehensively to achieve regional KPI performance targets.

13.4.11.1.1.2. Contractor shall participate in two KPI initiatives:

13.4.11.1.1.2.1. PCMP KPI incentive program that enables PCMPs to earn incentive payments based on achieving PCMP practice-based quality target thresholds.

13.4.11.1.1.2.2. RAE KPI incentive program that enables Contractor to earn incentive payments based on achieving regional quality target thresholds.

13.4.11.1.1.3. Contractor shall comply with Department KPI specifications found in the data specifications document developed and maintained by the Department. This specifications document may be updated at any time by the Department in collaboration with Contractor. The Department, at its discretion, may modify the KPIs to align with federal and state initiatives and through consultation with RAEs and stakeholders.

13.4.11.1.2. ACC Investment Pool

13.4.11.1.2.1. Contractor may be eligible to earn additional payments from the ACC Investment Pool that will be created from any monies not distributed for KPI performance. The ACC Investment Pool may be used to reinforce and align evolving program goals and to focus Contractor attention on State and Department priority program outcomes.

13.4.11.1.2.2. Contractor may be eligible to receive payments from the ACC Investment Pool to:

13.4.11.1.2.2.1. Incentivize Provider and Contractor participation in state or federal initiatives that align with the ACC and other initiatives to be determined by the Department.

13.4.11.1.2.3. The Department will annually determine the ACC Investment Pool strategy, payment methodology, and distribution plan.

13.4.11.1.3. Behavioral Health Incentive Program

13.4.11.1.3.1. Subject to available funding, Contractor may be eligible to participate in a Behavioral Health incentive program as described in (Exhibit C, Payment).

13.4.11.1.3.2. 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 Contractor.

13.4.12. Additional Performance Measurement

13.4.12.1. Commitment to Quality Program

13.4.12.1.1. Contractor shall strive to achieve all the Performance Standards agreed to in the Work. Contractor shall commit to excellence in achieving these Performance Standards by contributing funding in the amounts detailed in this section when Contractor does not achieve annual performance expectations regarding Performance Standards as established and documented annually by the Department.

13.4.12.1.1.1. Contractor shall work with the Department and other MCEs to establish performance targets for specified Performance Standards. The Department reserves the right to set a performance target based on historical data submitted by the MCEs if the MCEs and the Department cannot establish mutual agreement on a performance target.

13.4.12.1.1.2. Contractor and the Department shall agree on the funding distribution methodology no later than six months following the Department's acceptance of Contractor's state Fiscal Year quarter four Quarterly Financial Report. Contractor shall not distribute these funds to either Contractor, entities with ownership interest in Contractor, or the Department. Funds shall only be used for intents enumerated in this Work, such as but not limited to, supporting the health neighborhood(s), improving member health, improving access to care, or efforts to achieve KPI or shared savings goals. Funds shall not be used to enhance Provider reimbursement beyond 100% of their contractual terms for timely payment.

13.4.12.1.1.3. Contractor financial contributions made for missing Performance Standards shall be made from Contractor's profit margin, as defined by the difference between

total revenue earned through this Work and total expense for annual performance periods.

13.4.12.1.1.4. Contractor shall bear the responsibility of proving that financial contributions are deducted from Contractor's profit margin during the quarterly financial review meetings with the Department.

13.4.12.1.1.5. Contractor shall not pass on the cost of these contributions to the Commitment to Quality Program to Network Providers or Subcontractors that support the Work. Contractor shall not absorb the cost of this reimbursement by reducing staff or resources dedicated to the Work, or other actions that would likely have a negative impact on Members or Network Providers.

13.4.12.1.2. Funding the Commitment to Quality Program

13.4.12.1.2.1. Contractor shall contribute the following amount of funding to the Commitment to Quality Program following a determination by the Department of the number and percent of the Performance Standards Contractor achieved during the previous state Fiscal Year:

13.4.12.1.2.1.1. Zero percent of Contractor's profit margin if Contractor meets 90% or more of the Performance Standards.

13.4.12.1.2.1.2. Five percent of Contractor's profit margin if Contractor meets 85-89% of the Performance Standards.

13.4.12.1.2.1.3. 15% of Contractor's profit margin if Contractor meets 80-84% of the Performance Standards.

13.4.12.1.2.1.4. 25% of Contractor's profit margin if Contractor meets less than 80% of the Performance Standards.

13.4.12.2. Public Reporting

13.4.12.2.1. Contractor shall improve network performance on Department-determined federal, state, and contract measures that will be reported publicly at least one time annually. The Public Reporting measures may include, but are not limited to, the following:

13.4.12.2.1.1. KPIs.

13.4.12.2.1.2. Behavioral Health incentive program measures.

13.4.12.2.1.3. CMS Adult and Child Core Measure sets.

13.4.12.2.1.4. Clinical and Utilization measures as relevant, including HEDIS measures that align with other state and federal initiatives.

13.4.12.2.1.5. BHA established performance metrics.

13.4.12.2.1.6. Member experience of care.

13.4.12.2.1.7. Utilization Management and operational information, including authorizations and denials of services.

13.4.12.3. Health Equity and Performance Improvement

13.4.12.3.1. Contractor shall disaggregate their performance and utilization data at least by race and ethnicity, language, gender, age, and disability status in strategic priority areas as

defined by the Department's Health Equity Plan and make this information available to the Department and stakeholders upon request.

13.4.12.3.2. Contractor shall collaborate with the Department and stakeholders in the development of health equity measures, which may require the addition of new measures or the adjustment of existing measures.

13.4.12.3.3. Over the performance period for any or all performance measures, Contractor shall collaborate with the Department to understand performance results, collect high quality data for measurement, and develop and implement interventions to improve performance results to the benefit of Members and Providers.

13.5. Member Experience of Care

13.5.1. Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by Contractor and Network Providers.

13.5.2. Contractor shall use tools to measure Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, call center data, and Grievance and Appeals data.

13.5.3. Contractor shall assist the Department or its designated vendor with the annual administration of the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) and any subsequent survey tool required by CMS for both adults and children.

13.5.3.1. Contractor shall work with the Department to customize CAHPS and to develop a sampling methodology.

13.5.3.2. Contractor shall develop strategies with the Department to increase Member participation in the health plan CAHPS survey.

13.5.4. Contractor shall support the BHA in administering any surveys among Members accessing Behavioral Health services at Safety Net Providers and other contracted Behavioral Health Providers.

13.5.5. Contractor shall use the results and data from CAHPS, surveys for Behavioral Health, and all other surveys conducted by Contractor to inform Contractor's Quality Improvement Plan.

13.5.6. Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

13.5.6.1. Contractor shall monitor interventions and report on them at least one time annually in the Annual Quality Report.

13.5.6.2. Contractor shall develop a corrective action plan for a Network Provider when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is substantiated.

13.5.7. Contractor shall design and document a member experience of care strategy as part of the Annual Quality Plan and Report that shall include, but is not limited to, the following information:

13.5.7.1. Strategy to survey Members who accessed services during a recent period of time as defined by Contractor, but no less than one time annually.

13.5.7.2. Strategy to survey Members who were assigned to Contractor during the previous 12 months.

13.5.7.3. Process to analyze Contractor's call center information and Grievances and Appeals data to better understand Members' experience.

13.5.7.4. Process to assist the Department and BHA with survey implementation.

13.5.7.5. Analysis of findings regarding Member experience from the previous year and modifications Contractor has made to its operations in response to these findings.

13.5.7.6. Contractor's interventions and any corrective action plans with specific Network Providers based on Member experience findings.

13.5.7.7. Lessons learned from Contractor's activities to collect information about Member experience.

13.6. Mechanisms to Detect Overutilization and Underutilization of Services

13.6.1. Contractor shall implement and maintain mechanisms to detect overutilization and underutilization of services, and to assess the quality and appropriateness of care furnished to Members, including Members with special health care needs. Contractor may incorporate mechanisms developed for Contractor's Utilization Management program.

13.6.2. Client Over-Utilization Program (COUP)

13.6.2.1. Contractor shall partner with the Department in administering the COUP for Members who meet the criteria for inappropriate over-utilization of health care services.

13.6.2.2. Quarterly, Contractor shall process a Member list supplied by the Department of all the Members who have met the Department's overutilization criteria and were notified in writing of their overutilization.

13.6.2.2.1. When appropriate, Contractor may identify other Members for inclusion in COUP.

13.6.2.3. Contractor shall outreach and intervene with Members identified as meeting overutilization criteria in accordance with the Care Coordination requirements in Section 8 in order to link the Members to appropriate and available services.

13.6.2.4. Contractor shall monitor Members' utilization of services and pharmaceuticals and coordinate ongoing care.

13.6.2.5. For Members who remain on the overutilization list after a period of intervention, Contractor shall perform a clinical review to determine the appropriateness of restricting the Member to either one medical Provider and/or one pharmacy (lock in).

13.6.2.5.1. Contractor shall appear as an expert witness in a State Fair Hearing for a Member who has appealed lock-in status.

13.6.2.6. Contractor shall recruit Providers to serve as lock-in Providers.

13.6.2.6.1. Contractor shall educate Providers on what it means to be a lock-in Provider, as well as provide informational materials.

13.6.2.6.2. Contractor shall provide technical assistance to Providers who will serve as primary lock-in Providers.

13.6.2.6.3. Contractor shall submit a quarterly COUP referral list to the Department for members who are determined to be appropriate for lock-in.

13.6.2.6.4. **DELIVERABLE**: COUP Lock-in Referral Report.

13.6.2.6.5. **DUE**: On the 10th calendar day of the second month of each quarter the report covers

13.7. External Quality Review

13.7.1. Contractor shall participate in an annual 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 CFR § 438 and the CMS mandatory activity protocols.

13.7.2. Contractor shall participate in an external quality review that includes a review of the:

13.7.2.1. Contractor’s activities in its role as a PCCM Entity

13.7.2.2. Contractor's activities in its role as a PIHP for the Capitated Behavioral Health Benefit.

13.7.2.3. Contractor’s administration of the Contract as an integrated program.

13.7.3. Contractor shall participate in an annual external review that may include, but is not limited to, the following:

13.7.3.1. Medical Record review. For external review activities involving Medical Record abstraction, Contractor shall obtain copies of the Medical Records from the sites in which the services reflected in the encounter occurred at no cost to the Department or its vendors.

13.7.3.2. Performance improvement projects and studies.

13.7.3.3. Surveys.

13.7.3.4. Network adequacy during the preceding 12 months.

13.7.3.5. Calculation and audit of quality and utilization indicators.

13.7.3.6. Quality of Care Grievances reviews.

13.7.3.7. Administrative data analyses.

13.7.3.8. Review of individual cases.

13.7.3.9. Care Coordination record review.

13.7.3.10. Provider site visits.

13.7.3.11. Encounter Data validation.

13.7.4. Contractor shall participate in the development and design of any external independent review studies to assess and assure quality of care. The final study specifications shall be at the discretion of the Department.

13.7.4.1. **PERFORMANCE STANDARD**: Contractor shall receive an aggregate score of 90% or greater on the annual compliance audit conducted by the external quality review organization.

13.8. Advisory Committees and Learning Collaboratives

13.8.1. To determine whether the Program is effectively serving Members and Providers, Contractor shall participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the Program overall and guiding the improvement of program performance.

13.8.2. Statewide Program Improvement Advisory Committees (PIAC)

13.8.2.1. Contractor shall participate in a statewide PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and Providers in the Program. For the statewide PIAC, Contractor shall, at minimum, perform the following:

13.8.2.1.1. Designate one of Contractor's Key Personnel to attend monthly meetings.

13.8.2.1.2. Nominate one representative from one of Contractor's regional PIACs or MACs to serve as a member of the statewide PIAC and have processes to make sure representatives consistently attend and participate in monthly meetings. The representative cannot be employed by Contractor.

13.8.3. Regional PIAC

13.8.3.1. Contractor shall create at least two Regional PIACs within Contractor's region to engage stakeholders and solicit guidance regarding the different needs and characteristics of the areas served.

13.8.3.2. Contractor shall confirm that the PIACs include, at a minimum, all of the following stakeholder representatives:

13.8.3.2.1. Members.

13.8.3.2.2. Members' families and/or caregivers.

13.8.3.2.3. PCMPs.

13.8.3.2.4. Behavioral Health Providers.

13.8.3.2.5. Health Neighborhood Provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

13.8.3.2.6. Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests.

13.8.3.3. Contractor's Regional PIAC shall have the following responsibilities:

13.8.3.3.1. Review Contractor's Deliverables.

13.8.3.3.2. Discuss program policy changes and provide feedback.

13.8.3.3.3. Provide representatives for the statewide PIAC.

13.8.3.3.4. Review Contractor's and Program's performance data.

13.8.3.4. Contractor shall have documented policies and procedures describing how its Regional PIACs address the following requirements:

13.8.3.4.1. Be directed and chaired by one of Contractor's Key Personnel as approved by the Department.

13.8.3.4.2. Have a formal, documented membership and governance structure that is posted on Contractor's website for public viewing.

13.8.3.4.3. Have a formal budget for the operations of the Regional PIAC, which may include a strategy for reimbursing Member participation.

13.8.3.4.4. Conduct regular meetings, no less than quarterly, in a format that encourages the active participation of Members and their family or caregivers and best meets the needs of Contractor's region.

13.8.3.4.4.1. Contractor shall utilize facilitation methods and resources to create an environment in which Members and their family or caregivers feel safe providing feedback.

13.8.3.4.5. Open all scheduled meetings to the public.

13.8.3.4.6. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

13.8.3.4.7. Accommodate individuals with disabilities.

13.8.4. Member Advisory Committee (MAC)

13.8.4.1. Contractor shall create at least two regional MACs within Contractor's region to engage stakeholders and solicit guidance regarding the different needs and characteristics of the areas served.

13.8.4.2. Contractor's MACs shall have the following responsibilities:

13.8.4.2.1. Discuss the Member experience of Contractor's activities and the delivery of Medicaid services within Contractor's region.

13.8.4.2.2. Discuss Contractor's and its Network Providers activities to advance culturally competent, accessible care within Contractor's region.

13.8.4.2.3. Discuss Contractor's policy changes and provide feedback.

13.8.4.2.4. Provide representatives for the statewide PIAC.

13.8.4.2.5. Review Contractor's and Program's performance data.

13.8.4.2.6. Review Member materials and provide feedback.

13.8.4.3. Contractor shall have documented policies and procedures describing how its Regional MACs address the following requirements:

13.8.4.3.1. Be directed and chaired by someone experienced in health equity, cultural and disability responsiveness, communication and Member engagement.

13.8.4.3.2. Have a formal budget for the operations of the Regional MAC, which may include a strategy for reimbursing Member participation.

13.8.4.3.3. Hold regular meetings, no less than quarterly, in a manner that supports the active participation of Members and their family or caregivers and best meets the needs of Contractor's region.

13.8.4.3.4. Post the agenda of each meeting on Contractor's website within seven days in advance of each meeting.

13.8.4.3.5. Post de-identified minutes of each meeting on Contractor's website within 30 days of each meeting.

13.8.4.3.6. Accommodate individuals with disabilities.

13.8.5. Regional Health Equity Committee

13.8.5.1. Contractor shall establish a Regional Health Equity Committee that shall discuss issues of equity and health disparities within Contractor's region.

13.8.5.2. Contractor shall ensure that the Regional Health Equity Committee includes, at a minimum, the following stakeholder representatives:

13.8.5.2.1. Members, including Members with disabilities.

13.8.5.2.2. PCMPs.

13.8.5.2.3. Behavioral Health Providers.

13.8.5.2.4. Health Neighborhood Provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

13.8.5.2.5. Advocacy organizations.

13.8.5.2.6. Community organizations, including local public health and child welfare agencies.

13.8.5.3. Contractor shall strive to ensure the membership of the Regional Health Equity Committee appropriately represents the demographic breadth of the region, with a focus on recruiting Black, Indigenous and Other People of Color (BIPOC), individuals with disabilities, and other focus populations identified in Contractor's Health Equity Plan.

13.8.5.4. Contractor's Regional Health Equity Committee shall have the following responsibilities:

13.8.5.4.1. Discuss health equity and accessibility challenges within Contractor's region and provide recommendations for addressing health disparities.

13.8.5.4.2. Inform the design of Contractor's Health Equity Plan and provide oversight of the plan's implementation.

13.8.5.4.3. Provide feedback on Contractor's and its Network Providers activities to advance health equity and accessibility within Contractor's region, particularly regarding Member engagement activities.

13.8.5.4.4. Review Contractor's and Program's health equity performance data.

13.8.5.5. Contractor shall ensure that its Regional Health Equity Committee:

13.8.5.5.1. Be directed and chaired by Contractor's Health Equity Officer.

13.8.5.5.2. Have a formal budget for the operations of the Regional Health Equity Committee, which may include a strategy for reimbursing Member participation.

13.8.5.5.3. Hold regular meetings, no less than two times annually, in a manner that supports the active participation of Members and individuals of different cultures, ethnicities, language preferences, and abilities.

13.8.5.5.4. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

13.8.5.5.5. Accommodate individuals who speak a primary language other than English.

13.8.5.5.6. Accommodate individuals with disabilities.

13.8.6. Quality Improvement Committee

13.8.6.1. Contractor shall have its Quality Improvement Director or their designee 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.

13.8.7. ACC Operations Meeting

13.8.7.1. Contractor shall have its Regional Contract Manager and other relevant staff members participate with Department staff and other RAE staff in the Department's ACC Operations meetings held at least one time per month. The Operations Meeting provides an opportunity for Contractor to learn about programs and policies impacting the ACC and Contractors, as well as to provide input and feedback regarding Department policies and the operations of the ACC.

13.8.8. Operational Learning Collaborative.

13.8.8.1. Contractor shall participate in Department Operational Learning Collaborative meetings to monitor and report on Contractor and ACC activities including, but not limited to, the following.

13.8.8.1.1. Wellness activities.

13.8.8.1.2. Provider payment models.

13.8.8.1.3. Health Promotion and Population Stratification and Management.

13.8.8.1.4. Member engagement.

13.8.8.1.5. Activities to promote health equity, cultural competency and disability accessibility within Network.

13.8.8.1.6. Health Neighborhood and Community development.

13.8.8.1.7. Provider support and practice transformation.

13.8.8.1.8. Data analytics.

13.8.8.1.9. Care Coordination, including cross-agency, cross-system activities.

13.8.8.1.10. Health information initiatives and technologies.

13.8.8.1.11. Strategies used to address social determinants of health.

13.8.8.1.12. Transitions of care, including hospital discharge and LTSS Members transitioning to the community.

13.8.8.2. Contractor shall share best practices and lessons learned with other RAEs while gaining insights from them to improve implementation of the ACC.

13.8.8.3. Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

13.8.9. Cost Collaborative

13.8.9.1. Contractor shall actively participate in a Department-led Cost Collaborative to identify and control unnecessary and/or avoidable costs within the Medicaid Program. One critical objective of this collaborative is to align incentives and focus across the health continuum from value-based payment strategies to quality performance objectives and care coordination risk stratification hierarchy.

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

13.8.9.3. Contractor shall work with the Department to identify and review at minimum, all of the following region specific areas of focus:

13.8.9.3.1. Cost outliers.

13.8.9.3.2. Programs not meeting engagement or savings targets.

13.8.9.3.3. System challenges impacting performance.

13.8.9.3.4. Gaps in data and information.

13.8.9.3.5. Standardized cost dashboards.

13.8.9.4. To support the Cost Collaborative, Contractor shall at minimum, perform all of the following:

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

13.8.9.4.2. Identify early areas of opportunities for cost management.

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

13.8.10. Behavioral Health Operations Meeting

13.8.10.1. Contractor shall host a quarterly meeting with representatives from the Department to review Contractor's performance administering the Capitated Behavioral Health Benefit.

13.8.10.2. Contractor shall, at a minimum, review all of the following information:

13.8.10.2.1. Behavioral Health network access.

13.8.10.2.2. Claims processing performance.

13.8.10.2.3. Utilization management performance.

13.8.10.2.4. Responsiveness to Provider complaints and Member Grievances.

13.8.10.2.5. Utilization trends.

13.8.10.2.6. Waitlists for any Behavioral Health services.

13.8.10.2.7. Hospital transition performance.

13.8.10.2.8. Performance managing children with high acuity needs.

13.8.10.2.9. Performance as it relates to any approved 1115 Demonstration waiver regarding Behavioral Health services.

13.8.10.2.10. Quality performance.

13.8.10.2.11. Activities to promote and support integrated Behavioral Health.

13.8.10.2.12. Other topics requested by the Department.

13.8.10.3. Contractor shall produce and submit relevant data reports to the Department two weeks prior to each quarterly meeting.

13.8.11. Program and Data (PAD) Meeting

13.8.11.1. Contractor shall actively participate in Department-led Program and Data Meetings to analyze Contractor's performance on quality metrics and other Department-identified priorities that may include outcomes of collaboration with CMAs and progress on outcome goals related to care coordination.

13.8.11.2. Contractor shall staff PAD meetings with data analytic, quality, and program staff educated in the topic being explored for each meeting.

13.8.11.3. Contractor shall conduct analyses in advance of each meeting and share Contractor's findings which shall include, at minimum, all of the following:

13.8.11.3.1. Performance trends.

13.8.11.3.2. Data gaps.

13.8.11.3.3. Promising practices and lessons learned.

13.8.11.3.4. Areas of opportunity.

13.8.11.3.5. Recommendations for how the Department can better support Contractor around the specific topic.

13.8.11.4. Contractor shall provide input and feedback regarding quality improvement priorities and measurements.

13.8.12. RAE Quarterly Leadership Meeting

13.8.12.1. Contractor shall collaborate with the Department on setting the agenda and preparing for a quarterly meeting with Department leadership (to include the Executive Director) to review Contractor performance that includes, but is not limited to, the following:

13.8.12.1.1. Care Coordination.

13.8.12.1.2. Administration of the Capitated Behavioral Health Benefit.

13.8.12.1.3. Population Health Management Report.

13.8.12.1.4. Network Adequacy Report.

13.8.12.1.5. Grievances and Appeals.

13.8.12.1.6. Member Engagement.

13.8.12.1.7. Administrative Payment Arrangements.

13.8.12.1.8. Client Over-Utilization Program.

13.8.12.1.9. Highlights of work with Health Neighborhood organizations.

13.8.12.1.10. Areas of opportunity and challenge to be addressed for Contractor to improve performance, including barriers to properly address those opportunities and challenges.

13.8.12.1.11. Provider areas of opportunity and where the Department can be of assistance.

13.9. Ad Hoc Quality Reports

13.9.1. Contractor shall provide to the Department or its agents any information or data relative to the Contract. In such instances, and at the direction of the Department, Contractor shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested.

13.9.1.1. Contractor shall have at least 30 calendar days, or a timeframe mutually agreed upon between the Department and Contractor, to fulfill such requests.

13.9.1.2. Contractor shall certify that data and information it submits to the Department is accurate.

14. COMPLIANCE AND PROGRAM INTEGRITY

14.1. Program Integrity Compliance Program Requirements

14.1.1. Contractor shall have a program in place for ensuring compliance with the ACC Program rules, Contract requirements, state and federal regulations and confidentiality regulations, and a program to detect Fraud, Waste and Program Abuse. Contractor shall ensure that all aspects of the ACC are focused on providing high-quality services that are of Medical Necessity in accordance with Contract requirements.

14.1.2. Contractor shall comply with all applicable CMS regulations in 42 CFR § 438.

14.1.3. Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims under the Contract, shall have a compliance program to implement and maintain arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Program Abuse.

14.1.4. The compliance program shall be approved by Contractor's Chief Program Officer and Compliance Officer.

14.1.5. Contractor shall ensure that the compliance program, at a minimum, includes:

14.1.5.1. Written policies and procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements.

14.1.5.2. 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 or the board of directors.

14.1.5.3. The establishment of a Regulatory Compliance Committee on the Board of Directors or at the senior management level charged with overseeing Contractor's compliance program and its compliance with the requirements under the Contract.

14.1.5.4. A system for training and education for the Compliance Officer, Contractor's Key Personnel, and Contractor's employees for the federal and state standards and requirements under the Contract.

14.1.5.5. Contractor shall ensure that this training is conducted in a manner that allows the Department to verify that the training has occurred.

14.1.5.6. Effective lines of communication between the Compliance Officer and Contractor's employees.

14.1.5.7. Enforcement of standards through well publicized disciplinary guidelines.

14.1.5.8. Establishment and implementation of procedures and a program integrity infrastructure that includes, at least:

14.1.5.8.1. Adequate systems and staff for routine internal monitoring and auditing of compliance risks.

14.1.5.8.2. Prompt response to compliance issues as they are raised.

14.1.5.8.3. Annual audits of one percent or more of claims paid for potential Fraud, Waste, and Program Abuse.

14.1.5.8.4. Investigation of potential compliance problems as identified in the course of self-evaluation and audits.

14.1.5.8.5. 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.

14.1.5.9. Contractor shall ensure that the compliance program includes the following processes:

14.1.5.9.1. Screening all Provider claims processed or paid by Contractor collectively and individually, for Suspected Fraud, Waste or Program Abuse.

14.1.5.9.2. Identifying Overpayments to Providers, including but not limited to, instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.

14.1.5.9.3. Recovering Overpayments to Providers.

14.1.5.9.4. Identifying and promptly reporting to the Department instances of Suspected Fraud, Waste and Program Abuse. Contractor shall search for Fraud, Waste, and Program Abuse by reviewing for Provider outliers in utilization and billing, and cross check with Member complaints.

14.1.5.9.5. 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.

14.1.5.10. Contractor shall have a process for Network Providers to report and return Overpayments to Contractor, including, at least:

14.1.5.10.1. Requirements for Network Providers to report to Contractor when they have received an Overpayment.

14.1.5.10.2. To return the Overpayment to Contractor.

14.1.5.10.3. To notify Contractor in writing of the reason for the Overpayment within 60 calendar days after the date on which the Overpayment was identified.

14.1.5.11. Contractor shall supply the Department the information submitted by a Network Provider related to an identified Overpayment within 30 calendar days after receiving the same information.

14.1.5.11.1. Contractor may retain Overpayments returned by Network Providers when Contractor has met their MLR.

14.1.5.12. 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 Subcontractor 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.

14.1.5.13. Contractor shall comply with the Department policies related to recoveries of Overpayments.

14.1.5.13.1. Contractor shall not retroactively recover Provider payments if:

14.1.5.13.1.1. A Member was initially determined to be eligible for medical benefits pursuant to section § 25.5-4-205, C.R.S. when the Provider has an eligibility guarantee number for the recipient; or

14.1.5.13.1.2. Contractor makes an error processing the claim, but the claim is otherwise accurately submitted by the Provider.

14.1.5.13.2. Contractor shall not retroactively recover Provider payments after 12 months from the date a claim was paid, except in the following instances:

14.1.5.13.2.1. Medicare, commercial insurance, or third-party liability is the primary payer for a claim.

14.1.5.13.2.2. The claim is the subject of a state or federal audit, including audits contractually required by the Department.

14.1.5.13.2.3. The claim is subject to a law enforcement investigation.

14.1.5.13.2.4. The claim submitted was a duplicate.

14.1.5.13.2.5. The claim is fraudulent.

14.1.5.13.2.6. The Provider improperly billed the claim.

14.1.5.13.2.7. The claim was submitted with a billing code or diagnosis code that inaccurately or incorrectly resulted in reimbursement or bypassed prior authorization requirements.

14.1.5.13.3. If Contractor retroactively recovers a Provider payment that is equal to $1,000.00 or more, Contractor shall work with the Provider to develop a payment plan if the Provider requests a payment plan.

14.1.6. Contractor shall have a process for the prompt referral to the Department and the State Medicaid Fraud Control Unit (MFCU) of all cases where the agency or entity has actual and reasonable cause to believe that there is suspected Medicaid Fraud and Waste, Program Abuse and Patient Abuse, neglect, and exploitation, and false representation. The process shall be aligned with applicable requirements set forth in the General Provisions of this Contract, and applicable requirements in the Statement of Work and this section.

14.1.6.1. 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.

14.1.6.2. 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.

14.1.6.3. False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a Provider or Member who has actual knowledge of the truth or false nature of the statement, or by a Provider or Member who has actual knowledge of the truth or false nature of the statement, or by a Provider or Member acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

14.2. Compliance Plan Requirements

14.2.1. Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

14.2.2. Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor Providers and clients to detect and prevent aberrant billing practices, potential Fraud, Waste, and Program Abuse, and promptly address potential compliance issues and problems.

14.2.3. Contractor shall ensure the Compliance Plan, at minimum, includes all of the following:

14.2.3.1. A risk assessment of Contractor's various Fraud, Waste, and Program Abuse, and program integrity processes.

14.2.3.2. An outline of activities proposed for the next reporting year regarding, at least:

14.2.3.2.1. Compliance and audit activities, including, but not limited to:

14.2.3.2.1.1. Conducting prospective, concurrent, and/or post-payment reviews of claims, including, but not limited to:

14.2.3.2.1.1.1. Medical records reviews.

14.2.3.2.1.1.2. Data mining.

14.2.3.2.1.1.3. Desk audits.

14.2.3.2.1.2. Verifying Provider adherence to professional licensing and certification requirements.

14.2.3.2.1.3. Verifying Provider records and other documentation to ensure services billed by Providers were actually rendered.

14.2.3.2.1.4. Reviewing goods provided and services rendered for Fraud, Waste and Program Abuse.

14.2.3.2.1.5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).

14.2.3.2.2. Contractor shall not include activities related to administrative billing issues, such as financial statement audits.

14.2.3.2.3. Education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud, Waste, and Program Abuse to ensure that all of its officers,

directors, managers, and employees know and understand the provisions of Contractor's Compliance Program and Compliance Plan.

14.2.3.2.4. Provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud, Waste, and Program Abuse and on identifying and educating targeted Providers with patterns of incorrect billing practices and/or Overpayments.

14.2.3.2.5. Cost avoidance measures taken to avoid improper payments from being made.

14.2.3.2.6. Descriptions of specific controls in place for prevention and detection of:

14.2.3.2.6.1. Overpayments and potential or Suspected Fraud, Waste, and Program Abuse, including but not limited to:

14.2.3.2.6.1.1. Automated pre-payment claims edits.

14.2.3.2.6.1.2. Desk audits on post-payment review of claims.

14.2.3.3. Work plans for the next year regarding conducting both announced and unannounced site visits and field audits to Network Providers to ensure services are rendered and billed correctly.

14.2.4. Contractor shall submit its Compliance Plan to the Department for review and approval. Contractor shall only submit finalized Compliance Plans to the Department for review and approval; the Department will not accept draft versions.

14.2.4.1. **DELIVERABLE**: Compliance Plan

14.2.4.2. **DUE**: May 15, 2025

14.2.5. Contractor shall review its Compliance Plan and make any necessary revisions for the following reporting year. Contractor shall submit revised Compliance Plans to the Department for review and approval.

14.2.5.1. **DELIVERABLE**: Compliance Plan documents and information

14.2.5.2. **DUE**: Annually, by July 31, starting in the second SFY

14.2.6. Contractor shall modify the Compliance Plan as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

14.2.6.1. **DELIVERABLE**: Compliance Plan revisions and changes

14.2.6.2. **DUE**: Ten Business Days following the Department's request

14.3. Reports and Disclosures

14.3.1. Contractor shall follow all requirements in this Exhibit B, Section 14.3 to notify the Department of all work, activities and events occurring under the requirements of Exhibit B, Section 14.1.

14.3.1.1. Reports Requiring Monthly Notification

14.3.1.1.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one-month period.

14.3.1.1.2. Contractor shall report, at minimum:

14.3.1.1.2.1. All identified or recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, and dates when Overpayments were recovered or a self-disclosure.

14.3.1.1.2.2. All suspended claim reimbursements and payments to a Provider, including information on whether the suspension is related to an audit or fraud case, including the dates of when reimbursements and payments were suspended.

14.3.1.1.2.3. All Provider circumstance changes where a Provider is no longer in Contractor's network, but was not removed for cause, including providing information on why the Provider was withdrawn.

14.3.1.1.2.4. Any Provider terminations not based on quality or performance or for cause, including, but not limited to:

14.3.1.1.2.4.1. A change in ownership or control of a Provider.

14.3.1.1.2.4.2. A Provider voluntarily withdrawing from Contractor's network.

14.3.1.1.2.4.3. The death of a Provider.

14.3.1.1.2.4.4. In all cases of Provider terminations, Contractor shall provide the following:

14.3.1.1.2.4.4.1. Date of removal.

14.3.1.1.2.4.4.2. Reason for the termination.

14.3.1.1.2.4.4.3. Numbers of Members served by the Provider.

14.3.1.1.2.4.4.4. Plan to ensure that Members receive continuous services.

14.3.1.1.2.4.5. Any other information as specified by the Department.

14.3.1.1.3. Contractor shall submit the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report.

14.3.1.1.3.1. **DELIVERABLE**: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

14.3.1.1.3.2. **DUE**: Within ten Business Days after the end of each month

14.3.1.1.4. Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within 10 Business Days following the receipt of the Department's requested changes.

14.3.1.1.4.1. **DELIVERABLE**: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

14.3.1.1.4.2. **DUE**: Within ten Business Days following the Department's request

14.3.1.2. Reports Requiring Semi-Annual Notification

14.3.1.2.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a six-month period.

14.3.1.2.2. The six-month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

14.3.1.2.3. Contractor shall submit the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report.

14.3.1.2.4. Contractor shall report and deliver, at minimum, all of the following:

14.3.1.2.4.1. A narrative outlining the compliance activities listed below and an explanation for any audits that were mentioned in the previous compliance plan that were not completed or any audits that were added after the compliance plan submission.

14.3.1.2.4.2. All audits or reviews which have been started, are on-going, or completed as part of the compliance program and Compliance Plan, including, at least:

14.3.1.2.4.2.1. Issue(s) being reviewed or audited.

14.3.1.2.4.2.2. The status of the review or audit.

14.3.1.2.4.2.3. The start and end dates of services covered by the review or audit.

14.3.1.2.4.2.4. The start and end dates of the review or audit.

14.3.1.2.4.3. All instances of Suspected Fraud, Waste and Program Abuse, discovered and reported to the Department and the MFCU, including:

14.3.1.2.4.3.1. The suspected issue.

14.3.1.2.4.3.2. The start and end dates of the services suspected to involve fraud.

14.3.1.2.4.3.3. The approximate amount of the claims affected and the date of report to the

14.3.1.2.4.3.4. Department and the MFCU.

14.3.1.2.4.4. All verification conducted of member services, including:

14.3.1.2.4.4.1. The number of notices sent to Members to verify and report whether services billed by Providers were actually received by Members.

14.3.1.2.4.4.2. The number of responses received, number of responses warranting further action.

14.3.1.2.4.5. All identified or recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including:

14.3.1.2.4.5.1. Whether the Overpayment was related to an Audit or Fraud case.

14.3.1.2.4.5.2. Dates of when Overpayments were identified.

14.3.1.2.4.5.3. Dates when Overpayments were recovered.

14.3.1.2.4.5.4. Any other information as specified by the Department.

14.3.1.2.5. Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

14.3.1.2.5.1. **DELIVERABLE**: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

14.3.1.2.5.2. **DUE**: Within 45 days after the end of the six-month reporting period

14.3.1.2.6. Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

14.3.1.2.6.1. **DELIVERABLE**: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

14.3.1.2.6.2. **DUE**: Within ten Business Days following the Department's request

14.3.1.3. Disclosures Requiring Prompt Notification

14.3.1.3.1. Provider Terminations and Disaffiliations

14.3.1.3.1.1. Contractor shall follow the process established by the Department to disaffiliate any PCMP from their network.

14.3.1.3.1.2. Contractor shall complete the disaffiliation no less than 10 Business Days prior to the end of the month.

14.3.1.3.1.3. Contractor shall notify the Department of any PCMP contract termination and disaffiliation no later than the 25th of every month.

14.3.1.3.1.4. Contractor shall notify the Department of the decision to terminate any existing Network Provider on the basis of quality or performance issues or for cause per 10 CCR 2505-10, § 8.076.1.7.

14.3.1.3.1.5. Contractor shall provide the following:

14.3.1.3.1.5.1. Provider's name and identification number.

14.3.1.3.1.5.2. Date of removal.

14.3.1.3.1.5.3. Number of Members served by the Provider.

14.3.1.3.1.5.4. Reason for the termination.

14.3.1.3.1.5.5. Narrative describing how Contractor intends to provide or arrange services for affected Members after the termination.

14.3.1.3.1.5.6. Any additional information as required by the Department.

14.3.1.3.1.5.6.1. **DELIVERABLE**: Notice of Network Provider Termination for Quality of Performance or For Cause

14.3.1.3.1.5.6.2. **DUE**: Within two Business Days after the decision to terminate for quality or performance issue terminations or terminations for cause

14.3.1.3.1.6. Contractor shall submit to the Department a list of all Network Providers that have been or will be disaffiliated or terminated from Contractor's network within the month.

14.3.1.3.1.6.1. **DELIVERABLE**: Notice of Network Provider Termination for Quality of Performance or For Cause

14.3.1.3.1.6.2. **DUE**: By the 25th day of the month in which a Network Provider has been or is scheduled to be disaffiliated or terminated from Contractor's network

14.3.1.3.2. Changes in Member Circumstances Affecting Eligibility

14.3.1.3.2.1. In accordance with 42 CFR § 438.608 (a)(3), Contractor shall promptly notify the Department when Contractor 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:

14.3.1.3.2.1.1. Changes in the Member's residence.

14.3.1.3.2.1.2. The death of a Member.

14.3.1.3.2.2. Contractor shall submit the Provider/Member Change in Circumstance Disclosure.

14.3.1.3.2.3. Contractor shall provide, at minimum, all of the following:

14.3.1.3.2.3.1. The Member's name.

14.3.1.3.2.3.2. Medicaid ID number.

14.3.1.3.2.3.3. Date of change.

14.3.1.3.2.3.4. Description of the change.

14.3.1.3.2.3.5. Any additional information as required by the Department.

14.3.1.3.2.3.5.1. **DELIVERABLE**: Monthly Member Change in Circumstance Disclosure Report

14.3.1.3.2.3.5.2. **DUE**: Within ten Business Days after the end of each month

14.3.1.3.3. Overpayments

14.3.1.3.3.1. Contractor, or any Subcontractor delegated responsibility by Contractor for coverage of services and payment of claims under this contract, shall implement and maintain arrangements or procedures for prompt reporting within ten business days after all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.

14.3.1.3.3.1.1. **DELIVERABLE**: Notice of Overpayments Identified or Recovered

14.3.1.3.3.1.2. **DUE**: Within ten Business Days after identification or recovery of an overpayment

14.3.1.4. Disclosures Requiring Notification within 30 Days

14.3.1.4.1. Provider Licensure and Professional Review Actions

14.3.1.4.1.1. Contractor shall report all adverse licensure and professional review actions it has taken against any Provider, in accordance with 45 CFR Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank, to the Department, and to the appropriate state regulatory board. The following is a list of reportable actions:

14.3.1.4.1.1.1. Malpractice payments.

14.3.1.4.1.1.2. Licensure and certification actions.

14.3.1.4.1.1.3. Negative actions or findings.

14.3.1.4.1.1.4. Adverse actions.

14.3.1.4.1.1.5. Health Care-related criminal convictions.

14.3.1.4.1.1.6. Health Care-related civil judgments.

14.3.1.4.1.1.7. Exclusions from federal or state health care programs.

14.3.1.4.1.1.8. Other adjudicated actions of decisions.

14.3.1.4.1.1.8.1. **DELIVERABLE**: Notification of Adverse Licensure of Professional Review

14.3.1.4.1.1.8.2. **DUE**: Within 30 days following the date Contractor made an adverse licensure or professional review action

14.3.1.5. Disclosures Requiring Notification within 60 days

14.3.1.5.1. Overpayments and Excess Capitation Payments

14.3.1.5.1.1. Within 60 calendar days after identifying any Overpayments, per 42 CFR 438.608(d)(2), and any excess capitation payments, Contractor shall report and return an Overpayment to the Department.

14.3.1.5.1.2. Contractor shall provide the following:

14.3.1.5.1.2.1. Member information.

14.3.1.5.1.2.2. Claims information.

14.3.1.5.1.2.3. Encounter data information.

14.3.1.5.1.2.4. Paid amounts.

14.3.1.5.1.2.5. Provider information.

14.3.1.5.1.2.6. Dates of when Overpayment was identified and recovered.

14.3.1.5.1.2.7. Recovery amounts.

14.3.1.5.1.2.8. Capitation information.

14.3.1.5.1.2.9. Any other information as required by the Department.

14.3.1.5.1.3. Contractor shall use the Overpayment and Recovery Notification Disclosure template.

14.3.1.5.1.3.1. **DELIVERABLE**: Overpayment and Excess Capitation Disclosure

14.3.1.5.1.3.2. **DUE**: Within 60 calendar days after identifying excess capitation or other payments

14.4. Fraud, Waste, and Program Abuse

14.4.1. Contractor shall participate in routine meetings held by the Department to discuss issues related to program integrity compliance activities and Fraud, Waste, and Program Abuse involving Medicaid funds and resources. The frequency of such meetings shall be at the sole discretion of the Department.

14.4.2. Contractor shall temporarily suspend all review activities or actions related to any Provider upon request of the Department.

14.4.3. Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

14.4.4. Contractor shall provide expert assistance to the Department, the Department's 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.

14.4.5. Contractor shall provide expert assistance that includes, but is not limited to, the following topics:

14.4.5.1. Any reports made pursuant to this section.

14.4.5.2. Any medical records review or Medical Necessity findings or determinations made pursuant to this Contract.

14.4.5.3. Provider treatment and business practices.

14.4.5.4. Provider billing practices and patterns.

14.4.6. Contractor shall meet with the Department, the Department's contractors or the MFCU to explain any reports or findings made pursuant to the section. Contractor shall cooperate with and provide assistance, including testimony, with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the Program Integrity Section, the Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

14.4.7. Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when potential fraud is suspected without the approval of the Department.

14.4.8. Contractor shall not take any action that might interfere with an investigation of possible Fraud by the Department, the MFCU, or any other law enforcement entity. Contractor shall assist the Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation.

14.4.9. Contractor shall temporarily suspend all review activities or actions related to any Provider which Contractor suspects is involved in fraudulent activity. Contractor shall continue its investigation as requested by the Department.

14.5. Suspension of Payments Due to a Credible Allegation of Fraud

14.5.1. Contractor shall suspend payments due to a Credible Allegation of Fraud in full or in part only at the direction of the Department, in accordance with 42 CFR § 455.23.

14.5.2. Contractor shall release suspended payment amounts to the Provider within one payment cycle when directed to do so by the Department.

14.5.3. Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

14.5.4. The Department may suspend payments to Contractor if Contractor is under investigation for a Credible Allegation of Fraud.

14.5.5. When Contractor has suspended payments to a Provider due to a Credible Allegation of Fraud, Contractor shall create and provide to the Department a monthly report of payments which have been suspended.

14.5.5.1. **DELIVERABLE**: Suspended Payments Report

14.5.5.2. **DUE**: On the tenth Business Day of each month for the previous month where payments to a Provider have been suspended due to a credible allegation of Fraud

14.6. Quality Improvement Inspection, Monitoring, and Site Reviews

14.6.1. Contractor shall enable and support the Department or its designee to conduct site reviews of Contractor's, Subcontractors', or Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in the Department's sole discretion to determine compliance with applicable Department regulations and the requirements of this Contract.

14.6.2. Site Reviews may include, but are not limited to:

14.6.2.1. Determining compliance with:

14.6.2.1.1. State and federal requirements.

14.6.2.1.2. Contracts.

14.6.2.1.3. Provider agreements.

14.6.2.2. Medicaid service provision and billing procedures.

14.6.2.3. Medicaid Bulletins and Provider Manuals.

14.6.3. Contractor shall cooperate with Department site review activities to monitor Contractor performance.

14.6.4. Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

14.6.5. 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.

14.6.6. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

14.6.7. For routine Site Reviews, Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted by the Department or its designee for mutually agreed upon dates for a site review.

14.6.7.1. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to Contractor at least three weeks prior to the visit.

14.6.7.1.1. 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.

14.6.7.2. Contractor has a minimum of 30 days to submit the required materials for non-emergency reviews.

14.6.8. Contractor shall make available all records and documents related to the execution of this Contract, either on a scheduled basis, or immediately on an emergency basis, to the Department and its agents for Site Review.

14.6.8.1. Delays in the availability of such documents and records may subject Contractor to remedial actions. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.

14.6.9. The Department will transmit a written report of the Site Review to Contractor within 45 days after the Site Review. Contractor is allowed 30 days to review the preliminary report and respond to the findings. The final report will indicate, at least, areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

14.6.10. Contractor shall respond to any required actions identified by the Department or its designee, if necessary, with a corrective action plan within 30 days after the final written report, specifying the action to be taken to remedy any deficiencies noted by the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until Contractor is found to be in complete compliance. The Department will notify Contractor in writing when the corrective actions have been completed, accepted, and Contractor is considered to be in compliance with Department regulations and Contract.

14.6.10.1. 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.

14.6.10.2. For corrective action plans affecting the provision of Covered Services to Members, Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

14.6.10.3. The Department will not accept any data submitted by Contractor to the Department or its agents after the last site visit day towards compliance with the visit in the written report. The Department will only apply this data toward the corrective action plan.

14.6.11. Contractor shall understand that the Site Review may include reviews of a sample of Network Providers to ensure that Network Providers have been educated and monitored by Contractor about the requirements under this Contract.

14.6.12. If the Site Reviewers wish to inspect a Network Provider location, Contractor shall ensure that:

14.6.12.1. Network Providers make staff available to assist in the audit or inspection effort.

14.6.12.2. Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

14.7. Prohibitions

14.7.1. Contractor shall comply with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment. Contractor shall not pay a Network Provider for Provider-preventable conditions, as identified in the State Plan and 42 CFR § 438(g). Contractor shall ensure that Network Providers identify Provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

14.7.1.1. Contractor shall create a Provider Preventable Conditions Report that includes all Provider-preventable conditions. Contractor shall submit this report to the Department on an annual basis.

14.7.1.1.1. **DELIVERABLE**: Provider Preventable Conditions Report

14.7.1.1.2. **DUE**: Annually, by July 31.

14.7.2. Contractor shall ensure all Network Providers are enrolled with the Department as Medicaid Providers, consistent with Provider disclosure, screening, and enrollment requirements, and no payment is made to a Network Provider pursuant to this Contract if a Network Provider is not enrolled with the Department as Medicaid Provider. This provision does not require the Network Provider to render services to Fee-for-Service beneficiaries.

14.7.3. The Department will not make payment to Contractor, if Contractor is:

14.7.3.1. An entity that could be excluded from under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

14.7.3.2. 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.

14.7.3.3. 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:

14.7.3.3.1. Any individual or entity excluded from participation in federal health care programs.

14.7.3.3.2. Any individual or entity that would provide those services through an excluded individual or entity.

14.7.3.4. Contractor shall not pay a Provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

14.7.3.4.1. The Provider or Subcontractor is excluded from participation in federal health care programs.

14.7.3.4.2. The Provider of Subcontractor has a relationship described in the section on prohibited affiliations.

14.7.4. Prohibited Affiliations

14.7.4.1. Contractor is prohibited from having a relationship with an individual or entity that is excluded from participation in any federal health care program as described in Sections 1128 and 1128A of the Social Security Act.

14.7.4.2. Contractor shall not knowingly have a relationship with:

14.7.4.2.1. 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 CFR § 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.

14.7.4.2.2. 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 CFR § 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.

14.7.4.2.3. A person with ownership or more than five percent of Contractor's equity who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 CFR § 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.

14.7.4.2.4. 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 CFR § 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.

14.7.4.2.5. 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 CFR § 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.

14.7.4.3. Contractor shall provide written disclosure to the Department of any prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, as defined in 438.608(c)(1).

14.7.4.4. If the Department learns 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:

14.7.4.4.1. Must notify the Secretary of the Department of Health and Human Services (Secretary) of the noncompliance.

14.7.4.4.2. May continue an existing agreement with Contractor unless the Secretary directs otherwise.

14.7.4.4.3. May not renew or extend the existing agreement with Contractor unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

14.7.5. Prohibited Payments

14.7.5.1. Contractor shall not make payments:

14.7.5.1.1. 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:

14.7.5.1.1.1. Under the Contract 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).

14.7.5.1.1.2. 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.

14.7.5.1.1.3. 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.

14.7.5.1.2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

14.7.5.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

14.7.5.1.4. 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.

14.8. General Compliance and Program Integrity Requirements

14.8.1. Business Transaction Disclosures

14.8.1.1. Contractor shall submit full and complete information about:

14.8.1.1.1. The ownership of any Subcontractor with whom Contractor has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request.

14.8.1.1.2. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any Subcontractor, during the five-year period ending on the date of the request.

14.8.1.2. **DELIVERABLE**: Disclosure of Business Transactions

14.8.1.3. **DUE**: Within 35 days following a request by the Department or by the Secretary of the Department of Health and Human Services.

14.8.2. Ownership or Control Disclosures

14.8.2.1. Contractor shall disclose to the Department information regarding ownership or control interests in Contractor at the time of submitting a Provider application, at the time of executing the Contract with the State, at Contract renewal or extension, and within 35 days after either a change of ownership or a written request by the Department.

14.8.2.2. Contractor shall include the following ownership and control disclosure information in a form to be provided by the Department:

14.8.2.2.1. The name, title, and address of any individual or entity with an ownership or control interest in Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

14.8.2.2.2. Date of birth and Social Security Number of any individual with an ownership or control interest in Contractor.

14.8.2.2.3. Tax identification number of any corporation or partnership with an ownership or control interest in Contractor, or in any subcontractor in which Contractor has a five percent or more interest.

14.8.2.2.4. Whether an individual with an ownership or control interest in Contractor is related to another person with an ownership or control interest in Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which Contractor has a five percent or more interest is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling.

14.8.2.2.5. The name of any other Medicaid Provider (other than an individual practitioner or Group of Practitioners), Fiscal Agent, or MCE in which an owner of Contractor has an ownership or control interest.

14.8.2.2.6. The name, title, address, date of birth, and Social Security Number of any Managing Employee of Contractor.

14.8.2.2.6.1. **DELIVERABLE**: Ownership or Control Disclosures

14.8.2.2.6.2. **DUE**: Annually on July 31, and within 35 days after either a change of ownership or a written request by the Department.

14.8.3. Conflict of Interest

14.8.3.1. Contractor shall comply with the conflict of interest provisions outlined in Section 9, Conflict of Interest in the Contract Provisions along with all requirements in this Section.

14.8.3.2. Contractor shall comply with the conflict of interest safeguards described in 42 CFR § 438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

14.8.3.3. The term "conflict of interest" means that:

14.8.3.3.1. Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

14.8.3.3.2. 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.

14.8.3.3.3. A conflict of interest exists even if Contractor does not use information obtained from one party in Contractor's dealings with the other.

14.8.3.4. Contractor shall submit a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest.

14.8.3.4.1. **DELIVERABLE**: Conflict of Interest Disclosure Statement

14.8.3.4.2. **DUE**: Within ten Business Days after Contractor learns of an existing appearance of a conflict of interest situation

14.8.3.5. As required by § 25.5-5-402, C.R.S, Contractor may be required to submit quarterly data about rates paid to Providers in Contractor's network. If required to do so, Contractor shall submit required rate information on a template provided by the Department on the last day of each State fiscal quarter.

14.8.3.5.1. **DELIVERABLE**: Supplemental Conflict of Interest Data

14.8.3.5.2. **DUE**: Quarterly, on the last day of each State fiscal quarter

14.8.4. Subcontracts and Contracts

14.8.4.1. Contractor shall disclose to the Department copies of any existing subcontracts and contracts with Providers upon request.

14.8.4.2. Contractor shall ensure that no Member is billed by a Subcontractor or Provider for any amount greater than would be owed if Contractor provided the services directly or in violation of §§ 25.5-4-301(1)(a)(I), (II) and (II.5), C.R.S.

14.8.4.2.1. **DELIVERABLE**: Subcontracts and Provider Contracts

14.8.4.2.2. **DUE**: Within five Business Days after the Department's Request

14.8.5. Screening of Employees and Contractors

14.8.5.1. Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the Department of Health and Human Services - Office of the Inspector General (HHS-OIG).

14.8.5.2. Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of Contractor's employees and Subcontractors against the HHS-OIG's List of Excluded Individuals to determine whether each employee or Subcontractor has been excluded from participation in Medicaid.

14.8.5.3. If Contractor determines that one of Contractor's employees or Subcontractors has been excluded, then Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery to the Department.

14.8.5.3.1. **DELIVERABLE**: Notification of Discovery of Excluded Employee or Subcontractor

14.8.5.3.2. **DUE**: Within five Business Days after discovery

14.8.6. Disclosure of Information on Persons Convicted of Crimes

14.8.6.1. Upon submitting a Provider application, upon execution of the Contract, upon renewal or extension of the Contract, and within 35 days after the date of a written request by the Department, Contractor shall disclose the identity of any person who:

14.8.6.1.1. Has an ownership or control interest in Contractor, or who is a managing employee of Contractor; and

14.8.6.1.2. 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.

14.8.6.1.2.1. **DELIVERABLE**: Disclosure of Information on Persons Convicted of Crimes

14.8.6.1.2.2. **DUE**: Within 35 days after either a change of ownership or a written request by the Department.

14.8.7. Security Breaches and HIPAA Violations

14.8.7.1. In the event of a breach of the security of sensitive data, Contractor shall immediately notify the Department of all suspected loss or compromise of sensitive data within five Business Days after the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

14.8.7.2. Contractor shall comply with the requirements of § 6-1-716, C.R.S and any other applicable state and federal laws and regulations.

14.8.7.3. Contractor shall report all HIPAA violations as described in the HIPAA Business Associates Addendum.

14.8.7.3.1. **DELIVERABLE**: Security and HIPAA Violation Breach Notification

14.8.7.3.2. **DUE**: Within five Business Days after Contractor becomes aware of the breach

14.8.8. Maintenance of Records

14.8.8.1. Contractor shall ensure that all of Contractor's Subcontractors and Providers comply with all record maintenance requirements of the Contract including Contract provisions outlined in Section 7 Contractor Records, of the Contract Provisions.

14.8.8.2. Notwithstanding any other requirement of the Contract, Contractor shall retain and require Subcontractors to retain, as applicable, Member Grievance and Appeal records in accordance with 42 CFR § 438.416, base data in accordance with 42 CFR § 438.5(c), MLR reports in accordance with 42 CFR § 438.8(k), and the data, information, and documentation specified is 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten years.

14.8.9. Inspection and Audits

14.8.9.1. In addition to the record-keeping and audit provisions outlined in Section 7, Contractor Records in the Contract Provisions, Contractor shall comply with the documentation, retention, and access requirements detailed in this Section.

14.8.9.2. Contractor shall allow the Department, CMS, HHS-OIG, the Comptroller General, and any of their designees to inspect and audit any records or documents of Contractor or Contractor's Subcontractors and shall allow the Department, CMS, HHS-OIG, the Comptroller General, and any of their designees to, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

14.8.9.3. Contractor shall cooperate with federal evaluators and make any data available for the federal evaluation, as is required under 42 CFR § 431.420(f) to support federal evaluation.

14.8.9.4. Notwithstanding any other provision in the Contract, Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General, and any of their designees this authority to inspect and audit Contractor's records and documents for ten years from the final date the Contract is active or from the date of completion of any audit, whichever is later.

14.8.9.5. Contractor shall allow CMS or CMS's agent or designated contractor and the Department or the Department's agent to conduct unannounced, on-site inspections for any reason.

14.8.9.6. In the event that right of access is requested, Contractor and/or Contractor's Subcontractors or Providers shall:

14.8.9.6.1. Make staff available to assist in any audit or inspection under the Contract.

14.8.9.6.2. Provide adequate space on the premises to reasonably accommodate Department, state, or federal or any of their designees' personnel conducting all audits, Site Reviews, or inspections.

14.8.9.6.3. The Secretary of Health and Human services, the Department of Health and Human Services, and the Department have the right to audit and inspect any books or records of Contractor or Contractor's subcontractors pertaining to the ability of Contractor or Contractor's subcontractor's ability to bear the risk of financial losses.

14.8.9.6.4. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of Contractor's, Subcontractor's or Providers' provision of care.

14.8.9.6.5. Contractor shall allow access to Contractor's claims system and claims data by Department staff for program integrity activities.

14.8.9.6.6. In consultation with the Department, Contractor shall participate in compliance monitoring activities and respond to any Department or Department's designee's 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.

14.8.9.7. Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five Business Days.

14.8.9.8. Contractor must have staff available to assist in any audit or inspection under the Contract.

14.9. Financial Reporting

14.9.1. To achieve the ACC's objective of greater accountability and transparency, Contractor shall participate in a robust financial reporting program.

14.9.2. In addition to the conflict-of-interest provisions outlined in Section 9, Conflict of Interest in the Contract Provisions, Contractor shall comply with the disclosure and affiliation restrictions in this Section.

14.9.3. Contractor shall submit financial information to the Department on both a quarterly and annual basis, and attend quarterly meetings to review and discuss Contractor's financial information as follows:

14.9.3.1. Contractor shall quarterly compile financial information that shall include, but not be limited to, all of the following:

14.9.3.1.1. Quarterly internal financial statements, including balance sheet and income statement.

14.9.3.1.2. Quarterly trial balance listing all account numbers, descriptions, and amounts.

14.9.3.1.3. Crosswalk and/or allocation schedule(s) to link the quarterly trial balance to the Quarterly Financial Report.

14.9.3.1.4. Quarterly financial report using a template that has been agreed upon by Contractor and the Department. The report shall contain a detailed accounting of the total revenue received from the Department during the quarter and how payments were spent, including but not limited to, the following information:

14.9.3.1.4.1. The amount and percentage of payments Contractor spent during the reporting period to support the following categories of work:

14.9.3.1.4.1.1. 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).

14.9.3.1.4.1.2. Care Coordination, with a breakdown of dollars Contractor spent on contracted Care Coordination and Care Coordination provided by Contractor.

14.9.3.1.4.1.3. Practice support to include specific information about the types of practices supported.

14.9.3.1.4.1.4. Administration.

14.9.3.1.4.1.5. Network development.

14.9.3.1.4.1.6. Community infrastructure and Health Neighborhood participants.

14.9.3.1.4.1.7. Systems support and capital infrastructure investments.

14.9.3.1.4.1.8. Subcontractors.

14.9.3.1.4.1.9. The categories listed above may be expanded as a result of the process of developing the reporting template.

14.9.3.1.4.1.10. Incurred but not reported reserves, defined as the financial reserves held by Contractor to cover services or claims that have been incurred but not reported as of the evaluation date.

14.9.3.2. Contractor shall submit the Quarterly Financial Report to the Department.

14.9.3.2.1. **DELIVERABLE**: Quarterly Financial Report

14.9.3.2.2. **DUE**: No later than 45 days after the end of the State Fiscal quarter

14.9.4. Contractor shall compile an Audited Annual Financial Statement that includes, at a minimum, all of the following:

14.9.4.1. Annual internal financial statements, including balance sheet and income statement.

14.9.4.2. Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP). The audited annual financial statements must be certified by an independent public accountant and Contractor's Chief Financial Officer or their designee.

14.9.5. Contractor shall submit the Audited Annual Financial Statement to the Department.

14.9.5.1. **DELIVERABLE**: Audited Annual Financial Statement

14.9.5.2. **DUE**: No later than six months after the end of the SFY that the statement covers

14.9.6. Contractor shall participate in quarterly meetings with the Department to formally present and review Contractor's Quarterly Financial Report(s) submitted to the Department. These meetings will be held by the Department not more than 30 days after Contractor's submission

of each Quarterly Financial Report. Contractor shall ensure that the Chief Program Officer and Chief Financial Officer are in attendance at each meeting.

14.9.7. Contractor shall submit other financial reports and information as requested by the Department or the Department's designee.

14.9.8. 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:

14.9.8.1. Fact-checking.

14.9.8.2. Auditing reported data.

14.9.8.3. Performing site visits.

14.9.8.4. Requesting additional information.

14.9.9. If the Department determines that there are errors or omissions in any reported information, Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. Contractor shall submit the updated report to the Department within ten days after the Department's request for the updated report.

14.9.9.1. **DELIVERABLE**: Updated Financial Reports or Statements

14.9.9.2. **DUE**: Ten days after the Department's request for the updated report or statement

14.9.10. On a quarterly basis, Contractor shall provide information to demonstrate that it has sufficient terminal liability reserves for the purpose of financing claims incurred but not yet paid as well as related administration expenses to close down the plan in the event of Contractor's Medicaid plan dissolution or termination for any reason. For the purpose of this provision, a demonstration of sufficient terminal liability reserves means that Contractor provides financial information as required by the Department that shows compliance with the following: (a) Contractor reserves required under this section are sufficient to meet its outstanding claims liability under this contract as of the date of the report, (b) Contractor complies with the intent of Colorado Division of Insurance's statutory requirements at C.R.S. 10-16-411(1.5)(a)(I-II) even if Contractor is licensed to take financial risk under this contract in a structure other than an HMO, (c) Contractor has funding and resources that are at least equal to one month of capitated payments received by Contractor for services provided under this Contract.

14.10. Graduate Medical Education (GME) Hospital Report

14.10.1. Contractor shall submit GME data quarterly according to the specifications provided by the Department. Contractor shall certify all data submitted is accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. Contractor shall ensure that this certification is signed by either Contractor's Chief Program Officer or Chief Financial Officer (CFO) or by an individual who has delegated authority to sign for, and who reports directly to, Contractor's Chief Program Officer or CFO.

14.10.1.1. **DELIVERABLE**: GME Report

14.10.1.2. **DUE**: Quarterly on July 31, October 31, January 31, and April 30.

14.11. Solvency

14.11.1. Contractor shall notify the Department upon becoming aware of or having reason to believe that Contractor does not or may not meet the solvency standards, established by the state for health maintenance organizations.

14.11.2. Contractor shall not hold liable any Member for Contractor's debts, in the event Contractor becomes insolvent.

14.11.3. Contractor shall not hold liable any Member for covered services provided to the Member, for which the Department does not pay Contractor, or for which the Department or Contractor does not pay the Provider that furnished the service under a contractual, referral, or other arrangement.

14.11.4. Contractor shall not hold liable any Member for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor covered the services directly.

14.11.5. Contractor shall provide assurances satisfactory to the Department that Contractor's provision against the risk of insolvency is adequate to ensure that Members will not be liable for Contractor's debt, in the event Contractor becomes insolvent.

14.11.5.1. **DELIVERABLE**: Solvency Notification

14.11.5.2. **DUE**: Within two Business Days after Contractor becomes aware of a possible solvency issue.

14.12. Warranties and Certifications

14.12.1. Contractor shall disclose to the Department if Contractor is no longer able to provide the same warranties and certifications described in Section 1 as required at the Effective Date of the Contract.

14.13. Actions Involving Licenses, Certifications, Approvals, and Permits

14.13.1. Provider Insurance

14.13.1.1. Contractor shall ensure that Network Providers comply with all applicable local, state, and federal insurance requirements necessary in the performance of this Contract. Minimum insurance requirements shall include, but are not limited to, all the following:

14.13.1.1.1. Physicians participating in Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of $500,000.00 per incident and $1,500,000.00 in aggregate per year.

14.13.1.1.2. Facilities participating in Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of $500,000.00 per incident and $3,000,000.00 in aggregate per year.

14.13.1.1.3. Sections 14.13.1.1.1 and 14.13.1.1.2 shall not apply to Physicians and facilities in Contractor's network which meet any of the following requirements:

14.13.1.1.3.1. 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.

14.13.1.1.3.2. 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.

14.13.1.1.4. Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, Contractor shall notify the Department of such cancellation within two Business Days of when the coverage is cancelled.

14.13.1.2. Contractor shall notify the Department of:

14.13.1.2.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of § 10-16-401, et seq., C.R.S. as a Health Maintenance Organization.

14.13.1.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

14.13.1.2.3. Any revocation, withdrawal, or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

14.13.1.2.3.1. **DELIVERABLE**: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

14.13.1.2.3.2. **DUE**: Within two Business Days after Contractor's notification from Colorado Commissioner of Insurance

14.14. Federal Intermediate Sanctions

14.14.1. The Department may implement any intermediate sanctions, as described in 42 CFR § 438.702, if Contractor:

14.14.1.1. Fails substantially to provide medically necessary services that Contractor is required to provide, under law or under this Contract with the Department, to a Member covered under the Contract.

14.14.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

14.14.1.3. Acts to discriminate among Members on the basis of a Member's health status or need for health care services.

14.14.1.4. Misrepresents or falsifies information that Contractor furnishes to CMS or to the Department.

14.14.1.5. Misrepresents or falsifies information that Contractor furnishes to a Member, potential Member, or health care Provider.

14.14.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210.

14.14.1.7. Has distributed directly or indirectly through any agent or independent contractor that have not been approved by the Department or that contain false or materially misleading information.

14.14.1.8. Has violated any of the other applicable requirements of Sections 1903(m), 1932, or 1905(t) of the Social Security Act and any implementing regulations.

14.14.2. Notice of Sanction and Pre-Termination Hearing

14.14.2.1. Before imposing any of the intermediate sanctions specified in this Section 14.14.2, the Department must give Contractor timely written notice that explains the basis and nature of the sanction, and any other due process protections that the Department elects to provide.

14.14.2.2. In addition to the remedies and enforcement provisions outlined in Section 12 Remedies, of the Contract Provisions, Contractor shall be subject to the sanction and pre-termination hearing requirements set forth in this Section. Before terminating any contracts with Contractor, the Department must provide Contractor a pre-termination hearing.

14.14.2.3. Prior to a pre-termination hearing, the Department must provide Contractor with the following:

14.14.2.3.1. Written notice of the Department's intent to terminate, the reason for termination, and the time and place of the hearing.

14.14.2.3.2. After the hearing, the Department must provide Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination of the Contract.

14.14.2.3.3. For an affirming decision, give Members of Contractor notice of the termination and information on the Members' options for receiving Medicaid services following the effective date of termination of the Contract.

14.14.3. 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.

14.15. Termination Under Federal Regulations

14.15.1. In addition to the termination and enforcement provisions outlined in Section 12 Remedies, of the Contract Provisions, the Department may terminate this Contract for cause in accordance with the requirements set forth in this section and applicable federal regulations and enroll any Member enrolled with Contractor in another plan, or provide Member's Medicaid benefits through other options included in the State Plan, if the Department determines that Contractor has failed to:

14.15.1.1. Carry out the substantive terms of its contracts.

14.15.1.2. Meet applicable requirements in §§ 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

14.15.2. Before terminating Contractor's contract as described in this Section 14.15, the Department shall:

14.15.2.1. Provide Contractor a cure notice that includes, at a minimum, all of the following:

14.15.2.1.1. The Department's intent to terminate.

14.15.2.1.2. The reason for the termination.

14.15.2.1.3. The time and place for the pre-termination hearing.

14.15.2.2. Conduct a pre-termination hearing.

14.15.2.3. Give Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

14.15.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to Contractor that contains the effective date of the termination of the Contract.

14.15.2.4.1. Upon receipt of the termination notice, Contractor shall give Members enrolled with Contractor notice of the termination and information, consistent with 42 CFR § 438.10, on Members' options for receiving Medicaid services following the effective date of termination.

14.15.3. Once the Department has notified Contractor of the Department's intent to terminate under this section, the Department may give Members enrolled with Contractor written notice of the Department's intent to terminate the Contract.

14.15.4. The Department may choose to impose any of the following intermediate sanctions if Contractor violates any applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and its implementing regulations:

14.15.4.1. Allow Members enrolled with Contractor to Disenroll immediately, without cause.

14.15.4.2. Suspend all new enrollments to Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act.

14.15.4.3. Suspend payments for all new enrollments to Contractor's managed care capitation initiative until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

14.15.5. Should any part of Exhibit B relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the Department paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract, the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in the Department's payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

15. COMPENSATION

15.1. Summary of Compensation to Contractor

15.1.1. Compensation to Contractor will consist of the following:

15.1.1.1. A Care Management PMPM payment, as stated in Exhibit C, for each active Member assigned to Contractor on the first day of the month and for Members whose enrollment starts from the 2nd through the 17th of the month, excluding any Members enrolled in an MCO, if applicable.

15.1.1.2. An actuarially certified monthly Behavioral Health Capitated Payment, as specified in Exhibit C for each active Member assigned to Contractor on the first day of the month and for Members whose enrollment starts from the 2nd through the 17th of the month. The Department will set the monthly Capitated Payment rate at the actuarially certified point estimate in accordance with 42 CFR § 438.

15.1.2. Compensation to Contractor may consist of the following:

15.1.2.1. KPI incentive payments or ACC Investment Pool payments based on Contractor's performance.

15.1.2.2. An annual Behavioral Health incentive payment based on Contractor's performance of defined Behavioral Health metrics.

15.1.2.3. Shared savings payment based on Contractor's performance in supporting Contractor's network of PCMPs in achieving shared savings goals.

15.1.3. Contractor shall distribute PCMP-specified payments in accordance with Department requirements. The Department will provide Contractor with dedicated funding to make these payments for distribution to PCMPs. These PCMP specified payments may include:

15.1.3.1. PCMP KPI incentive payments based on an individual PCMP's performance.

15.1.3.2. PCMP access stabilization payments that support rural provider PCMPs, small clinic PCMPs, and pediatric PCMPs in providing Members access to critical primary care services, subject to state and federal authority.

15.2. Process for Care Management PMPM Payment and Capitated Payment

15.2.1. The Department will calculate the number of active Members enrolled with Contractor's based on the enrollment information in the interChange.

15.2.2. The Department will remit all Care Management PMPM payments and Capitated Payments through the interChange via electronic funds transfer to a bank account designated by Contractor. The Department will provide Contractor with a monthly payment report through the interChange.

15.2.2.1. Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

15.2.3. The Department will remit all PMPM payments and Capitated Payments to Contractor within the month for which the payment applies.

15.2.3.1. In the event that Contractor is not compensated for a Member in a month for which Contractor should have been compensated, the Department will compensate Contractor for that Member retroactively.

15.2.4. The Department may transition the Care Management PMPM payments to reflect the Work and regional variations within authorized State expenditure levels. The Department will consult with the Managed Care Entities to develop a methodology for this purpose.

15.3. Special Provisions for Monthly Capitated Payment

15.3.1. The monthly Capitated Payment shall be considered payment in full for all covered services set forth in Section 10.

15.3.2. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Section 10 and any other provision of the Contract, Section 10 shall prevail over other provisions of this Contract.

15.3.3. Actions Impacting Existing Rates

15.3.3.1. Contractor shall inform the Department prior to making changes to rate payment methodologies, Provider recoupments, or other financial adjustments that may impact the underlying assumptions the rate is built on.

15.4. Pay for Performance

15.4.1. RAE KPI Incentive Program

15.4.1.1. The Department will implement a RAE KPI incentive program through which Contractor may earn payment for meeting established performance goals.

15.4.1.2. The RAE KPI incentive payment will be set and paid as follows:

15.4.1.2.1. The Department will specify the amount of funding Contractor may earn through the RAE KPI incentive program in Exhibit C: Payment that shall not exceed 25% of a 25% withhold from the total Care Management PMPM payment allocated by the Department to Contractor.

15.4.1.2.2. The Department will pay an incentive payment to Contractor for each individual KPI that Contractor meets or exceeds the established performance goal published in the Department's annual KPI specifications document.

15.4.1.2.3. The Department will provide to Contractor documented calculation methodology in the annual KPI specifications document for all measures prior to the first distribution of funds. The Department will release the calculation methodology as a draft and will provide a comment period of no less than two weeks prior to releasing it as final. The Department will determine the final measurement and pay for performance criteria which will be published in the annual KPI specifications document.

15.4.1.2.4. The Department will remit all Payments on KPIs to Contractor within 180 days after the last day of the performance period in which the KPI incentive payments were earned. The Department will calculate the KPI incentive payment as of the end of each performance period based off Contractor's performance.

15.4.1.2.4.1. 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 annual KPI specifications document.

15.4.1.2.5. The Department will remit all incentive payments through the interChange.

15.4.2. ACC Investment Pool

15.4.2.1. The Department will determine the amount of funding that will be distributed and will distribute the monies in the ACC Investment Pool to Contractor based on an annual strategy created in consultation with the RAEs.

15.4.2.2. The Department will provide 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 weeks prior to releasing it as final.

15.4.2.3. The Department will remit all ACC Investment Pool payments through the interChange.

15.4.3. Shared Savings

15.4.3.1. If the Department chooses to implement a shared savings program through the ACC, the Department will document the shared savings program methodology in an annual ACC shared savings specifications document. The Department will calculate any shared savings awards for PCMPs and Contractor.

15.4.3.2. The Department will distribute aggregated regional shared savings payments to Contractor. Contractor shall distribute the Department calculated amounts to specified PCMPs.

15.4.3.3. The Department will remit all shared savings payments through interChange.

15.4.4. Behavioral Health Incentive Program Payment

15.4.4.1. The Department will implement a Behavioral Health incentive program enabling Contractor to receive incentive payments for the improvement of Behavioral Health incentive measures as described in Exhibit C.

15.4.4.2. The Behavioral Health incentive program will be implemented in accordance with 42 CFR § 438.6(b)(2) ensuring that the arrangement with Contractor:

15.4.4.2.1. Does not provide for payment in excess of 105% of the approved capitation payments.

15.4.4.2.2. 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.

15.4.4.2.3. Is not renewed automatically.

15.4.4.2.4. Is made available to both public and private contractors under the same terms of performance.

15.4.4.2.5. Is not conditioned on Contractor entering into or adhering to intergovernmental transfer agreements.

15.4.4.2.6. Is necessary to support program initiatives as specified in the state's quality strategy.

15.4.4.3. The Department will calculate the Behavioral Health incentive program payment as described in Exhibit C.

15.4.4.4. The Department will provide to Contractor documented calculation methodology for all measures prior to the first distribution of funds. The Department will release the calculation methodology as a draft and will provide a comment period of no less than two weeks prior to releasing it as final. The Department will determine the final measurement and pay for performance criteria.

15.4.4.5. The Department will distribute funding for achieving Behavioral Health incentive program performance annually by June 30 of every SFY following the measurement period for the Behavioral Health Incentive Program, as specified in the Behavioral Health incentive program specification document released annually by the Department.

15.5. PCMP Specified Payments

15.5.1. PCMP KPI Incentive Program

15.5.1.1. The Department will implement a PCMP KPI incentive program for PCMPs through which individual PCMPs may earn payment for meeting established performance goals.

15.5.1.2. The PCMP KPI incentive payment will be set and paid as follows:

15.5.1.2.1. The Department will determine the proportion of funds associated with the PCMP KPI incentive program that shall not exceed 75% of a 25% withhold from the total Care Management PMPM payment allocated by the Department to Contractor.

15.5.1.2.2. The Department will provide to Contractor documented calculation methodology in the annual KPI specifications document for all PCMP measures prior to the first distribution of funds. The Department will release the calculation methodology as a draft and will provide a comment period of no less than two weeks prior to releasing it as final. The Department will determine the final measurement and pay for performance criteria which will be published in the annual KPI specifications document.

15.5.1.2.3. The Department will remit all Payments on PCMP KPIs to Contractor within 180 days after the last day of the performance period in which the PCMP KPI incentive payments were earned. The Department will calculate the PCMP KPI incentive payment as of the end of each performance period based off individual PCMP performance and in accordance with the annual KPI specifications document.

15.5.1.2.3.1. The Department may consult with Contractor to modify the PCMP KPIs, PCMP KPI performance goals, and the individual PCMP KPI PMPM payment amounts by amendment to the Contract or the annual KPI specifications document.

15.5.1.2.4. The Department will remit all PCMP KPI incentive payments through the interChange.

15.5.1.2.4.1. Contractor shall distribute 100% of PCMP KPI incentive payments to individual PCMPs in accordance with Department distribution specifications.

15.5.2. PCMP Access Stabilization Payments

15.5.2.1. The Department will implement a PCMP access stabilization payment program for PCMPs through which individual rural Provider PMCPs, small clinic PCMPs, and pediatric PCMPs, as defined by the Department, may earn supplemental payments to support Member access to critical primary care services, pending state and federal authority.

15.5.2.2. The PMCP access stabilization payment will be set as follows:

15.5.2.2.1. The Department will set the amount for the PCMP access stabilization payment program in accordance with state budget authority that is separate from Contractor's Care Management PMPM.

15.5.2.2.2. The Department will provide to Contractor documented distribution methodology for identifying PCMPs eligible for the PCMP access stabilization payment and the allocation methodology prior to the first distribution of funds. The Department will release the methodology as a draft and shall provide a comment period of no less than two weeks prior to releasing it as final. The Department will determine the final PCMP eligibility criteria and allocation methodology and publish it in the annual PCMP access stabilization specification document.

15.5.2.2.3. The Department will calculate the number of active Members enrolled with PCMPs eligible for the PCMP access stabilization payment based on each eligible PCMP's enrollment information in the interChange and in accordance with the published annual PCMP access stabilization specification document.

15.5.2.2.4. The Department will remit all PCMP access stabilization PMPM payments to Contractor through the interChange. The Department will provide Contractor with a monthly PCMP access stabilization payment report through the interChange.

15.5.2.2.4.1. Contractor shall distribute 100% of PCMP access stabilization payments to individual PCMPs in accordance with Department distribution specifications and the monthly PCMP access stabilization payment report.

15.5.3. The Department will remit all PCMP access stabilization PMPM payments to Contractor within the month for which the payment applies.

15.6. Payment Calculation Disputes

15.6.1. In the event that Contractor believes that the calculation or determination of any payment is incorrect, Contractor shall notify the Department of its dispute within 30 days following Contractor's receipt of the payment calculation or determination. The Department will review calculations or determinations 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.

15.7. Recoupments

15.7.1. The Department shall recoup monthly Care Management PMPM payment, Capitated Payment amounts, pay for performance payments as defined in 15.4, or PCMP-specified payments as defined in 15.5 paid to Contractor in error. Error may be either human or machine error on the part of the Department, Contractor, or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, change in RAE or PCMP enrollment due to a Member choosing a new PCMP, or situations where the Member cannot use Contractor's facilities.

15.7.2. Contractor shall refund to the Department any overpayments due the Department within 30 days after Contractor or Department discovered the overpayments or being notified by the Department that overpayments are due. If Contractor fails to refund the overpayments within 30 days, the Department shall deduct the overpayments from the next payment to Contractor.

15.7.3. Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within 90 days after termination of the Contract.

15.7.4. Payments made by the Department to Contractor due to Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

15.7.5. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any monthly Care Management PMPM payments and Capitated Payments.

15.8. Contractor's obligation to refund all calculated rebates continues subsequent to the termination of the Contract.

15.9. Compensation

15.9.1. Contractor will receive payment as specified in Exhibit C, Payment.

15.10. Closeout Payments

15.10.1. Notwithstanding anything to the contrary in this Contract, all payments for the final month of this Contract shall be paid to Contractor no sooner than ten days after the Department has determined that Contractor has completed all of the requirements of the Closeout Period.

EXHIBIT C-1, PAYMENT

1. CARE MANAGEMENT PER-MEMBER-PER-MONTH (PMPM) PAYMENT

1.1. Effective July 1, 2025, through the duration of this Contract, Contractor shall be paid the following care management PMPM payments per Exhibit B, Section 15:

Description	**PMPM Amount**
Care Management PMPM	$17.06

1.2. Any changes to the Care Management PMPM payment must be executed via a Contract Amendment.

2. MONTHLY PAYMENT FOR CAPITATED BEHAVIORAL HEALTH BENEFIT EFFECTIVE JULY 1, 2025 – JUNE 30, 2026

2.1. Contractor shall earn full risk rates for behavioral health services as specified in Exhibit B, Section 15 and in accordance with Exhibit B, Section 10:

Example Cohort Set	Behavioral Health Rate
Elderly	$53.45
Disabled	$199.81
Non-Expansion Adult	$101.61
Expansion Parent	$66.09
Children	$57.90
Foster Care	$188.15
MAGI Adult	$171.77

2.2. 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 Department plus any cost sharing from the Members. Payments for carrying out Contract provisions, including incentive payments, are medical assistance costs.

2.3. For additional details on Covered Services, billing requirements, and compliance, refer to the State's Behavioral Health Services Billing Manual.

3. PRIME RATES EFFECTIVE JULY 1, 2025 – JUNE 30, 2026

Category of Aid	SFY26 Rate
Elderly	$186.46
Disabled Nondual	$1,736.39
Disabled Dual	$174.87
AFDC Male	$403.11
AFDC Female	$566.46
Expansion Parent F	$621.40
Expansion Parent M	$344.03
AWDC	$728.75
BC Women	$738.59

4. RISK CORRIDOR AND RECONCILIATION FOR BEHAVIORAL HEALTH PROGRAM EFFECTIVE JULY 1, 2025 – JUNE 30, 2026

4.1. Due to uncertainty associated with the implementation of a Prospective Payment System (PPS) model, all cohorts for this time period shall be subject to a PPS reconciliation calculation.

4.2. In addition, the transition from the Accountable Care Collaborative (ACC) 2.0 to ACC 3.0 introduces additional uncertainty to the general behavioral health program. As such, a tiered behavioral health risk corridor is included as a component to the risk mitigation structure.

4.3. This risk corridor is mutually exclusive from the Cover All Coloradans (CAC) risk corridor as laid out in Exhibit O.

4.4. The PPS reconciliation will apply to all contractors and Comprehensive Providers operating within the state of Colorado.

4.4.1. Contractor must meet with each Comprehensive Provider within 30 days of the end of each quarter to review the Comprehensive Provider's costs to determine if adjustments should be made to the payment arrangement between the provider and the Comprehensive Provider.

4.5. The Department, under a State Directed Payment authority (42 CFR 438.6), shall engage in a risk corridor with Contractor on services provided by Comprehensive Providers under the PPS model.

4.6. The tiered Risk Corridor shall be calculated by the Department, or its designee, prior to the calculation of the MLR, and any payments or recoupments shall be incorporated in the MLR calculation as an adjustment to revenue.

4.7. DIRECTED PAYMENT RECONCILIATION

4.7.1. Contractor shall engage in a reconciliation with any Comprehensive Providers where at least one of Contractor's Members has received services to incur a PPS encounter during the SFY 2026.

4.7.2. The reconciliation shall be calculated independent of any Value-Based-Purchasing (VBP) amount that Contractor pays outside of the State Directed Payment Amount.

4.8. DIRECTED PAYMENT RECONCILIATION PROCESS

4.8.1. The Contracted Comprehensive Providers will be paid directly by Contractor for the services described in 1.5.1. at their designated State Directed Payment PPS Rate determined by the Department as outlined in Ex. B, Section 14.

4.8.2. No later than April 1, 2027, the Department will use the audited or adjusted cost reports submitted by Comprehensive Providers to calculate and publish the Actual Cost PPS Rate that reflects the actual experience for SFY 2026.

4.8.3. Contractor will be responsible for reconciling the difference between Comprehensive Provider's State Directed Payment PPS Rate and the Actual Cost PPS Rate for the Comprehensive Provider for SFY 2026 through the date the Department publishes the Actual Cost PPS Rate.

4.8.3.1. PPS encounters are defined by the Department's PPS definition using the assigned procedure codes and trigger logic.

4.8.3.2. The count of PPS encounters for reconciliation with Comprehensive Providers will be the count of applicable encounters for each Comprehensive Provider incurred by Contractor with dates of service within the SFY 2026 as provided within the submitted encounter data with three months of runout.

4.8.4. In the event of a discrepancy between Contractor and a Comprehensive Provider as to the correct count of encounters, Contractor shall attempt to resolve the discrepancy directly with the Comprehensive Providers. If the discrepancy cannot be resolved within 10 Business Days, the

Department will have final say in the allowable count of PPS encounters for the purposes of the reconciliation.

4.9. DIRECTED PAYMENT RECONCILIATION COMPLETION

4.9.1. After finalizing the reconciliation calculation, Contractor will present and explain the calculations to the Comprehensive Provider, as well as issue a demand letter, if the Comprehensive Provider or notification letter for any amount due from, or due to, the contracted Comprehensive Providers.

4.9.2. Contractor shall recoup funds from the contracted Comprehensive Providers under the Directed Payment reconciliation, where applicable, within 30 days of Contractor issuing the demand letter.

4.9.3. Contractor shall reimburse the contracted Comprehensive Providers for any reconciliation, where applicable, within 30 days of Contractor issuing the notification letter.

4.10. SAFETY NET RISK CORRIDOR CALCULATION PROCESS

4.10.1. The first tier of the risk corridor shall be a Safety Net risk corridor relating only to the PPS portion of the actuarially sound rates.

4.10.2. For each rating cohort, exclusive of the CAC, the Department or its designee shall calculate a Safety Net PMPM as the portion of the actuarially sound PMPM composed of the medical portion of the comprehensive services to be paid under the PPS payment model.

4.10.3. The Department or its designee shall calculate a Target Safety Net PMPM as the weighted average of the Safety Net PMPMs by cohort, exclusive of the CAC, weighted by the actual member months for SFY 2026, with appropriate runout, as reported in the Department's system of record.

4.10.4. The Department, or its designee, will calculate an Adjusted Actual Safety Net PMPM as incurred PPS costs divided by member months, weighted by included cohort.

4.10.4.1. The numerator will be calculated by the Department, or its designee, as the PPS payment expenditures by included cohort, exclusive of value-based payments, reported through the annual encounter data and financial reporting services, incurred within the SFY 2026 with sufficient runout paid under the PPS payment model.

4.10.4.2. The denominator will be calculated by the Department, or its designee, as the actual member months for SFY 2026, with appropriate runout, as reported in the Department's system of record.

4.10.5. The Department will then calculate the ratio between the Adjusted Actual Safety Net PMPM and Contractor's Target Safety Net PMPM to determine the risk corridor range and the share of cost in the first tier of the risk corridor, based on the calculation table listed below.

4.10.5.1. The actuarially determined Target Safety Net PMPM is equivalent to one hundred percent (100%) in the risk corridor structure.

4.10.6. Risk corridor calculations will be made according to the following:

Corridor #	Risk Corridor Min	Risk Corridor Max	MCE Share	State Share
A	0.00%	89.99%	0%	100%

B	90.00%	109.99%	100%	0%
C	110.00%	+	0%	100%

4.10.7. The difference between the Adjusted Actual Safety Net PMPM and Contractor's Target Safety Net PMPM within Corridor B in the table above will be the Final Actual Safety Net PMPM that will be used in the behavioral health total risk corridor.

4.10.8. The difference between the Adjusted Actual Safety Net PMPM and Contractor's Target Safety Net PMPM in Corridor A or Corridor C in the table above will not be included in the behavioral health total risk corridor. Refer to Section 3.12 for the calculated difference.

4.11. BEHAVIORAL HEALTH PROGRAM TOTAL RISK CORRIDOR CALCULATION PROCESS

4.11.1. For each rating cohort, exclusive of the CAC, the Department or its designee shall calculate a Non-Safety Net PMPM as the portion of the actuarially sound PMPM composed of services that are not included in the Safety Net PMPM.

4.11.2. The Department or its designee shall calculate a Target Non-Safety Net PMPM as the weighted average of the Non-Safety Net PMPMs by included cohort weighted by the actual member months for SFY 2026, with appropriate runout, as reported in the Department's system of record.

4.11.3. The Department will combine the Target Safety Net PMPM and Target Non-Safety Net PMPM as the Target Total PMPM for the behavioral health program risk corridor.

4.11.4. The Department, or its designee, will calculate an Adjusted Actual Non-Safety Net PMPM as incurred costs divided by member months, weighted by included cohort.

4.11.4.1. The numerator will be calculated by the Department, or its designee, as the non-PPS payment expenditures by included cohort reported through the annual encounter data and financial reporting services, incurred within the SFY 2026 with sufficient runout paid under the non-PPS payment model.

4.11.4.2. The denominator will be calculated by the Department, or its designee, as the actual member months for SFY 2026, with appropriate runout, as reported in the Department's system of record.

4.11.5. The Department will combine the Final Actual Safety Net PMPM and Adjusted Actual Non-Safety Net PMPM to form the Final Actual Total PMPM for the behavioral health program risk corridor.

4.11.6. The Department will then calculate the ratio between the Final Actual Total PMPM and Contractor's Target Total PMPM to determine the risk corridor range and the share of cost, based on the calculation table listed below.

4.11.6.1. The actuarially determined Target Total PMPM is equivalent to one hundred percent (100%) in the risk corridor structure.

4.11.7. Risk corridor calculations will be made according to the following:

Corridor #	**Risk Corridor Min**	**Risk Corridor Max**	**MCE Share**	**State Share**

A	0.00%	94.99%	10%	90%
B	95.00%	97.99%	50%	50%
C	98.00%	101.99%	100%	0%
D	102.00%	104.99%	50%	50%
E	105.00%	+	10%	90%

4.12. RECOUPMENTS OR ADDITIONAL REIMBURSEMENT

4.12.1. In the above tables, a ratio of Actual to Target PMPMs of greater than 100% represents payment from the Department to Contractor. A ratio of less than 100% represents a payment from Contractor to the Department.

4.12.2. After finalizing the risk corridor calculation, the Department, or its designee, will present and explain the calculations to Contractor, as well as issue a demand/notification letter for any amount due from (or due to) Contractor.

4.12.3. Contractor shall remit any funds due under the risk corridor structure, where applicable, to the Department within 60 days of the Department issuing the demand letter.

4.12.4. The Department shall reimburse Contractor for any funds due under the risk corridor structure, where applicable, within sixty (60) days of the Department issuing the notification letter.

5. RETROSPECTIVE RATE CHANGES

5.1. In relation to unique circumstances and when Contractor and the Department agree to retrospectively change the rates, the Department will reconcile to recoup overpayments or supplement underpayments. The rates for the following time periods will be adjusted according to Contract Amendment issued by the Department.

5.1.1. [Intentionally left blank]

6. PAY FOR PERFORMANCE: BEHAVIORAL HEALTH INCENTIVE PROGRAM

6.1. The amount of the incentive payment is limited by federal regulation (42 CFR 438.6) and available state funding as notified in writing by the Department.

6.2. Behavioral Health Incentive Program Gate

Gate Activity	Percent of Earned Funds Available if Gate Activity is Met	Gate 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	50%	Submission of flat file with 100% accuracy for a minimum of three quarterly submissions and one annual

Contract term, in addition to the annual flat file		submission for a total of four submissions received by Deliverable due date during Fiscal Year performance period to receive 100% of funds Submission beyond due date for up to two months: Contractor eligible for participation at 20% reduction for each submission beyond due date. Contractor shall continue to resubmit inaccurate flat file submissions until corrected and accepted by the Department.

6.2.1. If Contractor meets the above mentioned minimum requirements, Contractor may qualify for incentive payments identified in Section 5.3.1 below based on minimum improvements in incentive performance measures and by percentage of compliance with incentive process measures.

6.3. Behavioral Health Incentive Program Measures

6.3.1. Minimum improvement for each incentive performance measure is defined as 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 the possible incentive performance measures and the percentage of incentive funding allocated for each measure. The Department will work with Contractor to negotiate what the appropriate baselines will be in the Behavioral Health Incentive Program specification document released annually by the Department.

	Incentive Performance Measure	**Percentage of Funding Allocated for Measure**
Indicator 1	Follow-Up after Emergency Department visit for Alcohol and Other Drug Abuse or Dependence.	20%
Indicator 2	Follow-Up after Hospitalization for Mental Illness.	20%
Indicator 3	Initiation and engagement of SUD treatment.	20%
Indicator 4	Follow-Up after Emergency Department Visit for Mental Illness.	20%
Indicator 5	Screening for Social Drivers of Health (SDOH).	20%

7. PAY FOR PERFORMANCE: KPI INCENTIVE PROGRAM

7.1. A total of $4.50 PMPM will be allocated for performance-based incentives.

Payment Category	Total Available PMPM Allocation	Performance Metrics & Section Reference	Distribution Requirements
Contractor Performance Incentive	$1.125 PMPM	RAE-only Metrics to be defined in the KPI Incentive Program specification document provided by the Department.	RAE may retain 100% of these funds.
Primary Care Medical Providers (PCMP) Incentive Payments	$3.375 PMPM	PCMP Performance Track: performance towards up to six key performance indicators. Exhibit B, Section 15.5.1 PCMP Practice Transformation Track: Demonstration of practice transformation initiatives and system improvements Exhibit B, Section 15.5.1	RAE must distribute 100% of these funds to PCMPs as directed by the Department. Department will calculate performance and payment for individual PCMPs.

7.2. Contractor Performance Incentive tiers, targets, and/or benchmarks will be specified in the KPI Incentive Program specification document released annually by the Department. The table above lists the possible incentive performance measures, and the total available funding allocated for each measure.

8. PCMP ACCESS STABILIZATION PASS-THROUGH PAYMENT

8.1. Pending state and federal authority, Contractor shall implement the Department's PCMP access stabilization payment program for qualifying rural, pediatric, and small clinic PCMPs in accordance with Exhibit B, Section 15.5.2. Contractor shall distribute 100% of PCMP access stabilization funding received from the Department to individual PCMPs in accordance with Department distribution specifications and the monthly PCMP access stabilization payment report.

9. PRIME PHARMACY RISK CORRIDOR

9.1. Risk Corridor for Pharmaceutical Drugs, effective July 1, 2025 through June 30, 2026

9.1.1. Due to uncertainty associated with the increasing utilization and cost of pharmaceutical drugs, the Department will implement a risk corridor for pharmaceutical drugs provided through a pharmacy within SFY 2025-2026. The risk corridor shall be calculated prior to the Medical Loss Ratio, and any reconciliations under the risk corridor shall be incorporated as an adjustment to revenue within the Medical Loss Ratio calculation.

9.2. Population Covered

9.2.1. The allowable population includes all members enrolled in Prime, excluding any members covered under Colorado house bill 21-1289 (Cover All Coloradans).

9.3. Requirements

9.3.1. The pharmaceutical drugs that qualify for the risk corridor calculation shall meet all of the following criteria:

9.3.1.1. Pharmaceutical drugs are provided through a licensed pharmacy and are not administered by a physician.

9.3.1.2. Pharmacy claims shall be submitted in the Certified Annual Flat File deliverable.

9.3.1.3. Pharmacy claims shall be incurred during SFY 2025-2026, according to the dispense date.

9.3.1.4. Claims shall contain a provider specialty code of 460 Mail Order, 461 Pharmacy, or 462 Pharmacy with DME.

9.4. Exclusions

9.4.1. The risk corridor is limited to retail pharmaceutical drugs. The following exclusions apply and cannot be included in the risk corridor calculations:

9.4.1.1. Pharmacy utilization and costs for members of Colorado house bill 21-1289 (Cover All Coloradans).

9.4.1.2. Physician administered drugs (PADs).

9.4.1.3. Hospital specialty drugs carved out of the APR-DRG or EAPG that are listed in the Department's Appendix Z.

9.5. Deliverables

9.5.1. Contractor shall report pharmacy claims for members in the Certified Annual Flat File deliverable as described in Section 11.3.10.

9.5.2. Department will conduct a review of the annual pharmacy encounter file to determine if the deliverable meets the requirements for the risk corridor reconciliation.

9.5.3. Contractor shall provide a report of the pharmacy supplemental rebates collected during SFY 2025-2026 in the Annual Certified Rate Setting Financial Template as described in Section 10.14.9.

9.5.4. Department will conduct a review of the pharmacy supplemental rebate report to determine if the deliverables meet the requirements for the risk corridor reconciliation.

9.6. Reconciliation Calculation Process

9.6.1. After the completion of SFY 2025-2026, the Department will use the annual pharmacy encounter data, submitted by the Contractor, to begin calculating the reconciliation.

9.6.2. Targeted PMPM Calculation

9.6.2.1. Department, or its designee, will calculate an aggregate pharmacy target PMPM, as a portion of the medical actuarially sound PMPM, for the contract period using the actual SFY 2025-2026 membership distribution on a cohort level basis.

9.6.3. Adjusted Actual PMPM Calculation

9.6.3.1. Department, or its designee, will calculate an Adjusted Actual PMPM for the contract period on a cohort level basis.

9.6.3.2. The Adjusted Actual PMPM shall reflect a reduction for any supplemental rebates collected by the Contractor for the allowable services.

9.6.3.3. The numerator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, using the submitted pharmacy rate-setting encounter data with three months runout and submitted financial information, inclusive of Incurred but Not Reported (IBNR) information.

9.6.3.4. The denominator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, as the incurred member months for the contract period as represented in the Department's system of record.

9.6.4. Department, or its designee, will calculate the ratio between the Adjusted Actual PMPM and the Target PMPM, at an aggregate level, to determine any cost sharing reconciliation based on the calculation table listed below.

9.6.5. The actuarially determined target PMPM is equivalent to one hundred percent (100%) in the risk corridor structure.

9.6.6. Risk corridor calculations shall be made according to the following tiered model:

Risk Corridor Lower Bound	Risk Corridor Upper Bound	Contractor Share	Department Share
0%	93.99%	25%	75%
94%	97.99%	50%	50%
98%	99.99%	100%	0%
100%	101.99%	100%	0%
102%	105.99%	50%	50%
106%	+	25%	75%

9.7. Recoupments or Additional Reimbursement

9.7.1. From the above table, a ratio of greater than 100% indicates a payment due from the Department to the Contractor. A ratio of less than 100% indicates a payment due from the Contractor to the Department.

9.7.2. Department will present the final calculations to the Contractor and allow 7 business days for feedback.

9.7.3. If a dispute arises, the Department's decision will prevail.

9.7.4. Department will issue a demand/notification letter for any amount due as recoupment from or payment to the Contractor.

9.7.5. Contractor shall reimburse the Department, where applicable, within sixty (60) days of the Department issuing the demand letter.

9.7.6. Department will reimburse the Contractor, where applicable, for risk corridor calculations within sixty (60) days of the Department issuing the notification letter.

EXHIBIT D, TERMINOLOGY

1. TERMINOLOGY

1.1. In addition to the terms defined in **§3** of this Contract, and in compliance with 42 CFR 438.10, Contractor shall use the state-developed definitions for applicable terms as outlined in this Exhibit. If a term relevant to this Contract is not expressly defined within this Exhibit, the applicable state-developed definition shall apply. In the absence of a state-developed definition, the term shall be construed in accordance with its definition under 42 CFR 438.10. The following list of terms shall be construed and interpreted as follows:

1.1.1. 1915(b)(3) Services – Alternative, non-State Plan Services described in 42 CFR § 440 and provided under the Department's 1915(b) waiver such as: Crisis Stabilization Units, Acute Treatment Units, Adult Mental Health Transitional Living Homes, Substance Use Disorder Partial Hospitalization Program, Recovery Supports, Assertive Community Treatment, Supporting Housing, Respite Services, and Behavioral Health Hotline Services.

1.1.2. Accountable Care Collaborative (ACC) – A program designed to affordably optimize Member health, functioning, and self-sufficiency. The primary goals of the ACC 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.

1.1.3. Admit, Discharge, and Transfer data (ADT) – A notification that leverages Electronic Health Record data to identify when a Member is admitted to a hospital, transferred to another facility, or discharged from the hospital.

1.1.4. 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 Service(s); reduction suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure of Contractor to act with the timeframes provided in 42 CFR § 438.408(b)(1) – (2) regarding the standard resolution of grievances and appeals; and the denial of an Member's request to dispute a financial liability.

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

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

1.1.7. 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.

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

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

1.1.10. 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.

1.1.11. 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 SUD services. The benefit operates under a monthly capitation.

1.1.12. Capitated Physical Health Benefit - A benefit that advances the physical and social well-being of all Members enrolled with a managed care organization. The benefit provides comprehensive State Plan and non-State Plan physical health and pharmacy services. The benefit operates under a monthly capitation.

1.1.13. 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.

1.1.14. Care Coordination – The deliberate organization of Member care activities between two or more participants (including the Member 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.

1.1.15. Care Management PMPM – Payment for PCCM Entity responsibilities as described throughout Exhibit B and in accordance with the 1915(b) waiver authority.

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

1.1.17. Child and Adolescent Needs and Strengths Tool (CANS) – A multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is a multipurpose information integration tool that is designed to be the output of an assessment process.

1.1.18. Child and Adolescent Needs and Strengths Tool (CANS) Decision Support Matrix – This term refers to the CANS decision support applications, which include the development of specific algorithms for levels of care including residential treatment (QRTP and PRTF), intensive community services, and Intensive Care Coordination. Algorithms can be localized for sensitivity to varying service delivery systems and cultures.

1.1.19. Child Health Plan Plus (CHP+) – Colorado's public low–cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Health First Colorado, but not enough to pay for private health insurance.

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

1.1.21. 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.

1.1.22. Colorado Crisis Services - Colorado Crisis Services is the statewide Behavioral Health crisis response system offering individuals mental health, substance use, or emotional crisis help, information and referrals.

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

1.1.24. 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.

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

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

1.1.27. Community Based Organizations (CBOs) – A public or private nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community and provides services to Members in that community.

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

1.1.29. 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 CFR § 438.2.

1.1.30. Consumer Price Index – The Consumer Price Index published by the US Department of Labor, Bureau of Labor Statistics.

1.1.31. 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.

1.1.32. Counties with Extreme Access Considerations (CEAC) - Counties with a population density of less than ten people per square mile, based on U.S. Census Bureau population and density estimates.

1.1.33. Covered Service – Those Medically Necessary health care services provide to Members, the payment or indemnification of which is covered under this Contract.

1.1.34. 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 CFR § 455.2.

1.1.35. Crisis Plan – A plan developed by a clinical provider or care coordinator in collaboration with a Member with an aim to prevent future Behavioral Health crises.

1.1.36. Cultural Responsiveness – Involves understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued.

1.1.37. Data – State Confidential Information and other State information resources transferred to Contractor for the purpose of completing a task or project assigned in the Statement of Work.

1.1.38. 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.

1.1.39. 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 CFR § 441.50 to 441.162, 42 CFR § 440.345, 42 U.S.C. 1902(a)(43) and 1905(a)(4)(B), and Medicaid Part V state manual.

1.1.40. Emergency Medical Condition – As defined in 42 CFR § 438.114(a), 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:

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

1.1.40.2. Serious impairment to bodily functions.

1.1.40.3. Serious dysfunction of any bodily organ or part.

1.1.41. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to deliver these services under 42 CFR. § 438, and needed to evaluate or stabilize an Emergency Medical Condition as defined in 42 CFR. § 438.114.

1.1.42. 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 CFR. § 438.2.

1.1.43. Enhanced Standardized Assessment – A robust biopsychosocial assessment which meets requirements outlined by the Behavioral Health Administration (BHA) and includes the use of the Child and Adolescent Needs and Strengths Tool (CANS).

1.1.44. Enhanced Standard Assessment completed by an Independent Person – In some cases, including but not limited to The Family First Prevention Services Act (FFPSA), a child/youth

will need an Enhanced Standardized Assessment completed by an Independent Person whose qualifications are defined by the Behavioral Health Administration.

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

1.1.46. 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.

1.1.47. 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).

1.1.48. 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.

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

1.1.50. Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person and includes any act that constitutes fraud under any federal or state law.

1.1.51. Freestanding Psychiatric Hospital – A hospital, 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.

1.1.52. 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 CFR. § 438.400 (b).

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

1.1.54. Goods – Any movable material to be acquired, produced, or delivered by Contractor which shall include any movable material acquired, produced, or delivered by Contractor in connection with the Services.

1.1.55. Health First Colorado – Colorado's Medicaid program.

1.1.56. 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.

1.1.57. 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.

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

1.1.59. Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act of 1996, as amended.

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

1.1.61. High-Fidelity Wraparound (HFW) – An individualized approach to helping children, youth, and families with complex needs. Service providers, natural supports and the youth and family work together to help achieve the family vision. The team honors the strengths, voice, and culture of the family to build confidence and experience success at home, in school, and in the community.

1.1.62. High Intensity Outpatient Providers – Providers that serve Members 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.

1.1.63. 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 Member 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.

1.1.64. 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.

1.1.65. Indirect Ownership Interest – 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.

1.1.66. 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.

1.1.67. Institutes for Mental Disease – A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease, 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.

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

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

1.1.70. Large Metro County – A county that meets the following combinations of population sizes and density parameters:

1.1.70.1. Greater than 1,000,000 persons with a population density greater than 1,000 persons per square mile.

1.1.70.2. A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than 1,500 persons per square mile.

1.1.70.3. Any population size with a population density greater than 5,000 persons per square mile.

1.1.71. 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.

1.1.72. Long-Term Services and Supports (LTSS) – A broad range of paid and unpaid medical and personal care assistance services that people may need for several weeks, months, or years when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. LTSS may be delivered in institutional or home and community-based settings (see "Home and Community Based Services). LTSS may include, but are not limited to, nursing facility care, adult day programs, home health aide services, personal care services, transportation, and supported employment, as well as associated care coordination and care planning services.

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

1.1.74. Managing Employee – 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.

1.1.75. Marketing – 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).

1.1.76. Medicaid System of Care (MSOC) – A coordinated network of community-based services and supports organized to meet the challenges of children and youth with or at risk for mental health or other challenges and their families in order to help them to function better at home, in school, in the community, and throughout life. The following are important components of the system of care services: family driven; individualized, strengths based, and evidence informed; youth guided; culturally and linguistically competent; provided in the least restrictive environment; community based; accessible; and collaborative and coordinated across an interagency network.

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

1.1.78. 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 Members.

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

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

1.1.81. Medication Assisted Treatment – Administration, management, and oversight of methadone or another approved controlled substance to an opiate dependent person for the purpose of decreasing or eliminating dependence on opiate substance.

1.1.82. Member – Any individual enrolled in the Colorado Medicaid program, Colorado's CHP+ program or the Colorado Indigent Care Program, as determined by the Department.

1.1.83. Metro County – A county that meets the following combinations of population sizes and density parameters:

1.1.83.1. Greater than 1,000,000 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 999.9 persons per square mile.

1.1.83.2. A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 1,499.9 persons per square mile.

1.1.83.3. A population size greater than or equal to 200,000 persons and less than or equal to 499,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 4,999.9 persons per square mile.

1.1.83.4. A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 100 persons per square mile and less than or equal to 4,999.9 persons per square mile.

1.1.83.5. A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 1,000 persons per square mile and less than or equal to 4,999.9 persons per square mile.

1.1.84. Micro County – A county that meets the following combinations of population sizes and density parameters:

1.1.84.1. A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 99.9 persons per square mile.

1.1.84.2. A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

1.1.85. 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.

1.1.86. 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.

1.1.87. 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.

1.1.88. Operational Start Date – When the Department authorizes Contractor to begin fulfilling its obligations under the Contract.

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

1.1.90. Out of Network Provider – Any Medicaid-enrolled provider that does not have a contracted relationship with Contractor for the delivery of Covered Services or other services and supports described in the Work.

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

1.1.92. Ownership – The possession of equity in the capital, stock, or profits of an entity.

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

1.1.94. Part 2 Data – Information the Department shares with Contractor that is covered under 42 CFR Part 2.

1.1.95. 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.

1.1.96. 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 CFR § 438.114(e), to improve or resolve the Member's condition.

1.1.97. 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 CFR § 438.2.

1.1.98. Prevalent Language – 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 CFR § 438.10(a).

1.1.99. Primary Care Case Management (PCCM) – A system under which a primary care case manager contracts with the Department 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 Department to provide a defined set of functions as defined in 42 CFR § 438.2.

1.1.100. 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 Member 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 Member 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 CFR § 438.2.

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

1.1.102. Primary Care Medical Provider (PCMP) Practice Assessment Tool – A Department-approved, standardized tool to assess and tier PCMPs and establish level of care standards for serving Members with health care needs of increasing complexity. Compensation for PCMPs will be based on the practice assessment tier as well as the complexity of the Members they serve.

1.1.103. 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.

1.1.104. 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.

1.1.105. 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.

1.1.106. 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.

1.1.107. 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.

1.1.108. Provider – Any health care professional or entity that has been accepted as a Provider in the Colorado Medicaid program, Colorado's CHP+ program or the Colorado Indigent Care Program, as determined by the Department.

1.1.109. Provider Dispute – 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 Contractor resolves in a timely fashion through existing informal processes.

1.1.110. 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).

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

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

1.1.113. Rural County– A county that meets the following combinations of population sizes and density parameters:

1.1.113.1. A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to ten persons per square mile and less than or equal to 99.9 persons per square mile.

1.1.113.2. A population size less than 10,000 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 4,999.9 persons per square mile.

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

1.1.115. Secret Shopper Survey - is an independent evaluation method used to assess a Medicaid managed care plan's Provider directory accuracy and appointment wait times. This survey involves covert testers ("secret shoppers") posing as Medicaid enrollees who attempt to schedule appointments with providers listed in the plan's directory.

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

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

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

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

1.1.120. 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.

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

1.1.122. State Fair Hearing – The process set forth in 42 CFR § 431 subpart E.

1.1.123. Subcontractor – Pursuant to Section 3 of the Contract Provisions, a Subcontractor is a third party engaged by the Contractor to aid in the performance of the Work under this Contract. For contracts involving a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Primary Care Case Management (PCCM) Entity, a Subcontractor includes any individual or entity that has a contract with an MCO, PIHP, or PCCM Entity that directly or indirectly relates to the performance of the MCO, PIHP, or PCCM Entity's obligations under its contract with the State. A Network Provider is not considered a Subcontractor solely by virtue of the Network Provider agreement with the MCO or PIHP, as defined in 42 CFR § 438.2..

1.1.124. Substance Use Disorder (SUD) – Treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use.

1.1.125. 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.

1.1.126. Treatment Plan – A plan developed by a clinical provider to focus on specific treatment goals.

1.1.127. Universal Contract – Provisions required in § 27-50-203, C.R.S to be used by state agencies and their contractors when contracting for Behavioral Health services in the state.

1.1.128. 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.

1.1.129. 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.

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

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

2. ACRONYMS AND ABBREVIATIONS

2.1. The following list is provided to assist the reader in understanding certain acronyms and abbreviations used in this Contract:

2.1.1. AAP – American Association of Pediatrics

2.1.2. ACC – Accountable Care Collaborative

2.1.3. ACT -Assertive Community Treatment

2.1.4. ADA – Americans with Disabilities Act of 1990

2.1.5. ADT – Admit, Discharge, Transfer data

2.1.6. API – Application Programming Interface

2.1.7. ARPA – American Rescue Plan Act

2.1.8. ASA – Average Speed of Answer
2.1.9. ASAM – American Society of Addiction Medicine
2.1.10. ASD – Autism Spectrum Disorder
2.1.11. ASL – American Sign Language
2.1.12. BAA – Business Associate Agreement
2.1.13. BHA – Behavioral Health Administration
2.1.14. BHASO – Behavioral Health Administrative Service Organizations
2.1.15. BIPOC – Black, Indigenous, and Other People of Color
2.1.16. CAHPS – Consumer Assessment of Healthcare Providers and Systems
2.1.17. CANS – Child and Adolescent Needs and Strengths tool
2.1.18. CAQH – Council for Affordable Quality Healthcare
2.1.19. CAT – Crisis Assessment Tool
2.1.20. CBMS – Colorado Benefit Management System
2.1.21. CBO – Community-Based Organization
2.1.22. CCD – Clinical Document
2.1.23. CCO – Chief Clinical Officer
2.1.24. CDOC – Colorado Department of Corrections
2.1.25. CDOI – Colorado Division of Insurance
2.1.26. CDT – Current Dental Terminology
2.1.27. CEAC – Counties with Extreme Access Considerations
2.1.28. CFO – Chief Financial Officer
2.1.29. CFR – Code of Federal Regulations
2.1.30. CHIA – Chief Health Information Technical Advisor
2.1.31. CHP+ – Child Health Plan Plus
2.1.32. CISP – Colorado Information Security Policy
2.1.33. CLIA – Clinical Laboratory Improvement Amendments
2.1.34. CMA – Case Management Agency
2.1.35. CMMI – Center for Medicare and Medicaid Innovation
2.1.36. CMS – Centers for Medicare and Medicaid Services
2.1.37. COPD – Chronic Obstructive Pulmonary Disorder
2.1.38. CORA – Colorado Open Records Act, §24–72–200.1, et. seq., C.R.S
2.1.39. COUP – Client Over Utilization Program
2.1.40. C.R.S. – Colorado Revised Statutes
2.1.41. CPI-U – CPI for all urban consumers

2.1.42. CPT – Current Procedural Terminology
2.1.43. CRM – Customer Relationship Management
2.1.44. DBA – Doing Business As
2.1.45. DO - Doctor of Osteopathic Medicine
2.1.46. D-SNP – Dual Eligible Special Needs Plan
2.1.47. E/M – Evaluation and Management CPT codes
2.1.48. ECP - Essential Community Provider
2.1.49. ED – Emergency Department
2.1.50. EDW – Enterprise Data Warehouse
2.1.51. EHR – Electronic Health Record
2.1.52. EPSDT – Early Periodic Screening, Diagnostic, and Treatment
2.1.53. EQRO – External Quality Review Organization
2.1.54. ESI – Enterprise Solutions Integrator
2.1.55. FHIR – Fast Healthcare Interoperability Resources
2.1.56. FQHC – Federally Qualified Health Center
2.1.57. GAD-7 – General Anxiety Disorder - 7
2.1.58. GME – Graduate Medical Education
2.1.59. HCBS – Home and Community Based Services
2.1.60. HCPCS – Healthcare Common Procedure Coding System
2.1.61. HEDIS – Healthcare Effectiveness Data and Information Set
2.1.62. HFW - High Fidelity Wraparound
2.1.63. HHS-OIG – Department of Human Services Office of the Inspector General
2.1.64. HIE – Health Information Exchange
2.1.65. HIOP – High Intensity Outpatient Provider
2.1.66. HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.
2.1.67. HIT – Health Information Technology
2.1.68. HMO – Health Management Organization
2.1.69. I/DD – Intellectual and Developmental Disabilities
2.1.70. IBHS – Intensive Behavioral Health Services
2.1.71. IDEA – Individuals with Disabilities Education Act
2.1.72. IHS – Indian Health Service
2.1.73. IHT – Inpatient Hospital Transition program
2.1.74. IMD – Institution for Mental Disease
2.1.75. IRL – Information Request List

2.1.76. IRS – Internal Revenue Services
2.1.77. JCAHO – Joint Commission on Accreditation of Health Care Organization
2.1.78. KPI – Key Performance Indicators
2.1.79. LEIE – List of Excluded Individuals
2.1.80. LSLPN – Limited Service Licensed Provider Network
2.1.81. LTSS – Long Term Services and Supports
2.1.82. MAC – Member Advisory Committee
2.1.83. MAYSI-2 – Massachusetts Youth Screening Instrument – Second Version
2.1.84. MCAAR – Managed Care Accuracy Audit Review
2.1.85. MCC – Member Contact Center
2.1.86. MCE - Managed Care Entity
2.1.87. MCO – Managed Care Organization
2.1.88. MD – Doctor of Medicine
2.1.89. MFCU – the Colorado Medicaid Fraud Control Unit in the Colorado Department of Law
2.1.90. MHPAEA – Mental Health Parity and Addiction Equity Act
2.1.91. MLR – Medical Loss Ratio
2.1.92. MOU – Memorandum of Understanding
2.1.93. MSOC – Medicaid System of Care
2.1.94. NCQA – National Committee for Quality Assurance
2.1.95. NEMT – Non-Emergent Medical Transport
2.1.96. NP – Nurse Practitioner
2.1.97. NPI – National Provider Identifier
2.1.98. NQTL – Non-Quantitative Treatment Limitation
2.1.99. OIT – Colorado Governor's Office of Information Technology
2.1.100. ONC – Office of the National Coordinator for Health Information Technology
2.1.101. PACE – Program for All-Inclusive Care for the Elderly
2.1.102. PAD – Program and Data Meetings
2.1.103. PAHP – Prepaid Ambulatory Health Plan
2.1.104. PAR – Prior Authorization Request
2.1.105. PCI – Payment Card Information
2.1.106. PCCM – Primary Care Case Management
2.1.107. PCMP – Primary Care Medical Provider
2.1.108. PDL – Prescription Drug List
2.1.109. PHI – Protected Health Information

2.1.110. PIAC – Program Improvement Advisory Committee
2.1.111. PIHP – Prepaid Inpatient Health Plan
2.1.112. PII – Personally Identifiable Information
2.1.113. PMPM – Per-Member Per-Month
2.1.114. PPQM – Provider Performance and Quality Measures
2.1.115. PRTF - Psychiatric Residential Treatment Facility
2.1.116. PSH – Permanent Supportive Housing
2.1.117. QI-1 – Qualified Individuals 1
2.1.118. QMB-only – Qualified Medicare Beneficiary only
2.1.119. QRTP - Qualified Residential Treatment Program
2.1.120. QWDI – Qualified Working Disabled Individuals
2.1.121. RAE – Regional Accountable Entity
2.1.122. RFP – Request for Proposal
2.1.123. RHC – Rural Health Clinic
2.1.124. SAP – Statutory Accounting Principles
2.1.125. SBHC – School-Based Health Center
2.1.126. SFY – State Fiscal Year
2.1.127. SHIE – Social Health Information Exchange
2.1.128. SLMB-only – Special Low-Income Medicare Beneficiaries only
2.1.129. SNAP – Supplemental Nutrition Assistance Program
2.1.130. SNF – Skilled Nursing Facility
2.1.131. SSUM – Statewide Standardized Utilization Management
2.1.132. SUD – Substance Use Disorder
2.1.133. TOC – Transitions of Care
2.1.134. TTY/TDD – Teletypewriters/Telecommunication Device for the Deaf
2.1.135. U.S.C. – United States Code
2.1.136. USCDI – United States Core Data for Interoperability
2.1.137. VARA – Visual Rights Act of 1990
2.1.138. WCAG – Web Content Accessibility Guidelines
2.1.139. WIC – Special Supplemental Nutrition Program for Women, Infants, and Children

EXHIBIT E, CONTRACTOR'S ADMINISTRATIVE REQUIREMENTS

1. CONTRACTOR'S GENERAL REQUIREMENTS

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

1.2. Contractor shall be responsible for performing all aspects of the Work as required under this Contract for the designated Regional Accountable Entity (RAE) service area. Contractor shall serve as the RAE for Region 1 for all of counties listed in Exhibit N, Map of Regions and Associated Counties.

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

1.4. 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.

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

1.6. 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 Work described in the Contract. Contractor shall make such records available to the Department upon request throughout the term of the Contract.

1.7. Deliverables

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

1.7.1.1. Contractor shall submit each Deliverable to the Department for review and approval and shall adhere to the following Deliverable process such for any documentation creation, review, and acceptable cycle, Contractor shall:

1.7.1.1.1. Gather and document requirements for the Deliverable.

1.7.1.1.2. Create a draft in the Department-approved format for the individual Deliverable.

1.7.1.1.3. Perform internal quality control review(s) of the Deliverable, including, but not limited to:

1.7.1.1.3.1. Readability.

1.7.1.1.3.2. Spelling.

1.7.1.1.3.3. Grammar.

1.7.1.1.3.4. Completion.

1.7.1.1.4. Adhere to all required templates or development of templates.

1.7.1.1.5. Perform modifications that include version control and tracked changes.

1.7.1.1.6. **PERFORMANCE STANDARD:** 95% of Deliverables specified in the Contract, by written request, or by formal transmittal process shall be submitted by the deadlines established by the Department.

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

1.7.1.2.1. 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.

1.7.1.2.2. 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.

1.7.1.3. 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.

1.7.2. Contractor shall employ an internal quality control process to ensure that all Deliverables are complete, accurate, easy to understand and of high quality, as described herein. 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.

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

1.7.3.1. **PERFORMANCE STANDARD:** 95% of Deliverables specified in the Contract, by written request, or by formal transmittal process shall be determined acceptable by the Department following Contractor's initial or second submission of the Deliverable.

1.7.4. 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.

1.7.5. 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.

1.7.6. 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.

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

1.8. Stated Deliverables and Performance Standards

1.8.1. 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.

1.9. Communication with the Department

1.9.1. Contractor shall enable all Contractor staff to exchange documents and electronic files with the Department staff in formats compatible with the Department's systems, including Microsoft Office products. Contractor shall communicate with the Department's primary designee, who will be identified to Contractor, to obtain information about the specific Microsoft products currently in use, as may be upgraded from time to time. At a minimum, Contractor shall have the capability to exchange documents and electronic files compatible with Microsoft Office 365, unless the Department's primary designee otherwise specifies. If Contractor uses a compatible program, then Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.

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

1.9.2.1. The date the transmittal will be effective.

1.9.2.2. Direction to Contractor regarding performance under the Contract.

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

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

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

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

available.

1.9.3.1. 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.

1.9.4. If Contractor receives conflicting transmittals, Contractor shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, to obtain direction. If the Department does not provide direction otherwise, then the transmittal with the latest effective date shall control.

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

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

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

1.10. Start-Up Period

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

1.10.2. Contractor shall receive no financial compensation during the Start-Up Period.

1.10.3. Contractor shall complete all requirements of the Start-Up Period and Start-Up Plan prior to the Operational Start Date, including the completion of the operation readiness review unless the Department provides written approval otherwise.

1.10.4. With input from the Department, Contractor shall complete all of the following during the Start-Up Period:

1.10.4.1. Schedule and facilitate a Kickoff Meeting that includes the following:

1.10.4.1.1. Key Personnel.

1.10.4.1.2. Department Leadership.

1.10.4.1.3. Department Project Team Members.

1.10.4.1.4. Any other relevant and needed persons or organizations.

1.10.4.2. Develop Kickoff Meeting materials and an agenda that contains, at a minimum, the following:

1.10.4.2.1. Initial timelines for starting the Work and creating initial Deliverables.

1.10.4.2.2. Establishment of Communication channels to describe how the Work is to be completed.

1.10.4.2.3. Any other item required to initiate and ensure Work is started and completed on time.

1.10.4.3. Prepare Kickoff Meeting Minutes and deliver them to the Department for review and approval.

1.10.4.3.1. **DELIVERABLE**: Kickoff Meeting Agenda & Materials

1.10.4.3.2. **DUE**: Within three Business Days after the Kickoff Meeting

1.10.4.4. Start-Up Plan

1.10.4.4.1. Contractor shall create and deliver a Start-Up Plan that contains, at a minimum, the following:

1.10.4.4.1.1. A description of all steps, timelines, and milestones necessary to fully transition the Accountable Care Collaborative Program described in the Contract from a prior contractor to Contractor.

1.10.4.4.1.2. A description of all steps, timelines, milestones, and Deliverables necessary for Contractor to be fully able to perform all Work by the Operational Start Date.

1.10.4.4.1.3. A listing of all personnel involved in the start-up and what aspect of the start-up they are responsible for.

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

1.10.4.4.1.5. Test system compatibility.

1.10.4.4.1.6. Established Provider Network and agreements.

1.10.4.4.1.7. Member and Provider materials and education.

1.10.4.4.1.8. Data as requested by the Department to inform the rate setting process.

1.10.4.4.1.9. The risks associated with the start-up and a plan to mitigate those risks.

1.10.4.4.1.9.1. **DELIVERABLE**: Start-Up Plan

1.10.4.4.1.9.2. **DUE:** Within five Business Days after the Effective Date

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

1.10.4.4.1.10.1. **DELIVERABLE:** Start-Up Plan Update

1.10.4.4.1.10.2. **DUE:** Within five Business Days after the Department's request for updates

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

1.10.4.5. Participate in an operational readiness review conducted by the Department. The operational readiness review may include additional review by the Department's Extenal Quality Review Organization (EQRO) for certain components in compliance with 42 CFR § 438.66. The operational readiness review shall be completed at least one month before the Operational Start Date. The readiness review consists of a desk audit and may also include a Site Review. The operational readiness review shall cover the following:

1.10.4.5.1. Administrative staffing and resources.

1.10.4.5.2. Delegation and oversight of MCO, PIHP, or PCCM Entity responsibilities including, at minimum, the following:

1.10.4.5.2.1. Provider communications.

1.10.4.5.2.2. Grievance and Appeals.

1.10.4.5.2.3. Member communication, services, and outreach.

1.10.4.5.2.4. Provider network management.

1.10.4.5.2.5. Program Integrity/Compliance.

1.10.4.5.2.6. Case management/Care Coordination/service planning.

1.10.4.5.2.7. Quality improvement.

1.10.4.5.2.8. Utilization Management review.

1.10.4.5.2.9. Financial reporting and monitoring.

1.10.4.5.2.10. Financial solvency.

1.10.4.5.2.11. Claims management.

1.10.4.5.2.12. Encounter data and enrollment information management.

1.10.4.5.2.13. Staff hiring and training.

1.10.4.6. Contractor shall participate in regular meetings with the Department to ensure Contractor is achieving milestones established in Contractor's Start-Up Plan and will be ready for the Operational Start Date.

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

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

1.10.4.8.1. **DELIVERABLE**: Contractor's Colorado Division of Insurance license

1.10.4.8.2. **DUE**: Upon the Effective Date

1.11. Operations Guide

1.11.1. Contractor shall not perform any Work under this Contract before the Operational State Date, except for the Work explicitly required in Exhibit E (Start-Up Phase and Plan) and Exhibit B (Statement of Work) with Due Dates prior to the Operational Start Date, including but not limited to the requirements outlined in Sections 1.9 and 1.10 of Exhibit E. The Department shall not be liable for, and Contractor shall not receive, any payment for Work performed before the Operational Start Date, except as specifically authorized for Start-Up activities in Exhibit E or required deliverables in Exhibit B.

1.11.2. Contractor shall create and implement an Operations Guide. The Operations Guide shall include the creation and management of the following:

1.11.2.1. Communication Plan.

1.11.2.2. Business Continuity Plan.

1.11.2.3. Start-Up Plan.

1.11.2.4. Closeout Plan.

1.11.3. Contractor shall submit the Operations Guide to the Department for review and approval.

1.11.3.1. **DELIVERABLE**: Operations Guide

1.11.3.2. **DUE**: Within 30 Business Days after the Effective Date

1.11.4. Contractor shall review its Operations Guide on annual basis and determine if any modifications are required to account for any changes in the Work, in the Department's processes and procedures or in Contractor's processes and procedures and update the Guide as appropriate to account for any changes. Contractor shall submit an Annual Operations Guide Update that contains all changes from the most recently approved prior Operations Guide or Annual Operations Guide Update or shall note that there were no changes.

1.11.4.1. **DELIVERABLE**: Annual Operations Guide Update

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

1.11.5. The Operational Start Date shall not occur until Contractor has completed all requirements of the Operations Guide, unless the Department provides written approval otherwise.

1.11.6. Communication with Members, Providers, and Other Entities

1.11.6.1. Contractor shall create a Communication Plan that includes, but is not limited to, all of the following:

1.11.6.1.1. A description of how Contractor will communicate to Members any changes to the services those Members will receive or how those Members will receive the services.

1.11.6.1.2. A description of the communication methods, including things such as email lists, newsletters and other methods, that Contractor will use to communicate with Providers and Subcontractors.

1.11.6.1.3. The specific means of immediate communication with Members and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

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

1.11.6.1.5. A listing of the following individuals within Contractor's organization, including cell phone numbers and email addresses:

1.11.6.1.5.1. An individual who is authorized to speak on the record regarding the Work, the Contract or any issues that arise that are related to the Work.

1.11.6.1.5.2. An individual who is responsible for any website or marketing related to the Work.

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

1.11.7. Business Continuity Plan

1.11.7.1. 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:

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

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

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

1.11.7.1.3. How Contractor will maintain complete back-up copies of all data, databases, operating programs, files, systems, and software pertaining to enrollment information at a Department-approved, off-site location.

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

1.11.7.1.5. 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.

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

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

1.11.8. Closeout Plan

1.11.8.1. Contractor shall create a Closeout Plan that describes all requirements, steps, timelines, milestones, and Deliverables necessary to fully transition the services described in the Contract from Contractor to the Department or to another contractor selected by the Department to be Contractor after the termination of the Contract.

1.11.8.1.1. 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.

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

1.11.8.2. Contractor shall provide weekly updates to the Department throughout the creation of and the performances within the Operations Guide, that show Contractor's status toward meeting the milestones described herein.

1.11.8.3. Contractor shall be ready to perform all Work by the Operational Start Date.

1.12. Closeout Period

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

1.12.1.1. Implement the most recent Closeout Plan or Closeout Plan Update as approved by the Department in the Operations Guide, as described herein 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.

1.12.1.2. 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.

1.12.1.3. 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.

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

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

1.12.1.5.1. **DELIVERABLE**: Member Notifications

1.12.1.5.2. **DUE**: 30 days prior to termination of the Contract

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

1.12.1.6.1. **DELIVERABLE**: Provider Notifications

1.12.1.6.2. **DUE**: 60 days prior to termination of the Contract

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

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

1.13. Accreditation

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

1.13.1.1. Accreditation status, survey type, and level.

1.13.1.2. Accreditation results including recommended actions, corrective action plans, or findings.

1.13.1.3. Expiration date of the accreditation.

1.14. Performance Reviews

1.14.1. The Department will monitor performance of the Work performed under this Contract.

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

1.14.3. The Department may work with Contractor in the completion of any performance reviews or

evaluations or the Department may complete any or all performance reviews or evaluations independently, at the Department's sole discretion.

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

1.14.5. 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.

1.14.6. 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.

1.14.7. At the Department's discretion the Department may put Contractor on an Action Monitoring plan or Corrective Action plan.

1.14.7.1. Action Monitoring Plan - this tool is used when the performance issue is not resolved after repeated clarification and feedback, or if the issue is new but does not pose a high risk to member care, the Department, or the Work performed under the term of this Contract.

1.14.7.2. Corrective Action Plan - this tool is used when the informal Action Monitoring Plan was not effective or when the issue is pervasive, urgent, or high-risk to member care or the Department, or the Work performed under the term of this Contract.

1.14.7.3. **PERFORMANCE STANDARD**: If Contractor is placed on an Action Monitoring Plan during the performance year, this performance standard shall be considered not met.

1.14.7.4. **PERFORMANCE STANDARD**: If Contractor is placed on an Action Monitoring Plan, 95% of timelines are met during the performance year as established in the Action Monitoring Plan.

1.14.7.5. **PERFORMANCE STANDARD**: If Contractor is placed on a Corrective Action Plan during the performance year, this performance standard shall be considered not met.

1.14.7.6. **PERFORMANCE STANDARD**: If Contractor is placed on a Corrective Action Plan, 95% of timelines are met during the performance year as established in a Corrective Action Plan.

1.15. Renewal Options and Extensions

1.15.1. 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.

1.15.2. The Parties may amend the Contract to extend beyond seven 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.

1.15.3. In the event that the Contract is extended beyond seven years, the annual maximum compensation for the Contract in any of those additional years shall be set by the Department in the form of a PMPM.

1.15.4. The limitation on the annual maximum compensation in this Contract shall not include increases made specifically as compensation for additional Work added to the Contract.

1.16. Department System Access

1.16.1. In the event that Contractor requires access to any Department 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 Department's system. Contractor shall follow all Department policies, processes, and procedures necessary to gain access to the Department's systems.

1.16.2. Contractor shall be responsible for any costs associated with obtaining and maintaining access to systems needed to perform the Work under this solicitation, as determined by the Department. The Department will not reimburse Contractor for any costs associated with obtaining and maintaining access to Department systems.

1.17. Provider Fraud

1.17.1. Contractor shall notify the Department and the Colorado Medicaid Fraud Control Unit of the Colorado Department of Law (MFCU) if it identifies or suspects possible Provider Fraud as a result of any activities in its performance of this Contract.

1.17.2. Upon identification or suspicion of possible Provider Fraud, Contractor shall complete Contractor Suspected Fraud Written Notice Form provided by the Department.

1.17.2.1. For each incident of identified or suspected Provider Fraud, Contractor shall provide all of the following, at a minimum:

1.17.2.1.1. Written documentation of the findings.

1.17.2.1.2. Information on any verbal or written reports.

1.17.2.1.3. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, in a format agreed to by the Department.

1.17.2.1.4. Information on the identification of any affected claims that have been discovered.

1.17.2.1.5. Any claims data associated with its report (in a mutually agreed upon format, if possible).

1.17.2.1.6. Any additional information as required by the Department.

1.17.3. For each incident of identified or suspected Provider Fraud, Contractor shall deliver the completed Contractor Suspected Fraud Written Notice Form to the Department and the MFCU.

1.17.3.1. **DELIVERABLE**: Completed Contractor Suspected Fraud Written Notice Form

1.17.3.2. **DUE**: Within three Business Days following the initial discovery of the Fraud or suspected Fraud

1.17.4. Contractor shall revise or provide additional information related to Contractor Suspected Fraud Written Notice Form as requested by the Department or the MFCU.

1.17.4.1. **DELIVERABLE**: Contractor Suspected Fraud Written Notice Revisions and Additional Information

1.17.4.2. **DUE**: Within three Business Days following the Department's or the MFCU's request, unless the Department or MFCU provides for a different period in its request.

1.18. Member Fraud

1.18.1. Contractor shall notify the Department if it identifies or suspects possible Member Fraud as a result of any activities in its performance of this Contract.

1.18.2. Upon identification or suspicion of possible Member Fraud, Contractor shall complete Contractor Suspected Fraud Written Notice Form provided by the Department.

1.18.2.1. For each incident of identified or suspected Member Fraud, Contractor shall provide all of the following, at a minimum:

1.18.2.1.1. All verbal and written reports related to the suspected fraud.

1.18.2.1.2. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, and the Member's State ID number, and Member's date of birth if applicable.

1.18.2.1.3. Information on the identification of any affected claims that have been discovered.

1.18.2.1.4. Any claims data associated with its report in a format agreed to by the Department.

1.18.2.1.5. Any additional information as required by the Department.

1.18.3. For each incident of identified or suspected Member Fraud, Contractor shall deliver the completed Contractor Suspected Fraud Written Notice Form to the Department at report.clientfraud@state.co.us, or at such other email address as provided by the Department from time to time.

1.18.3.1. **DELIVERABLE**: Completed Contractor Suspected Fraud Written Notice Form

1.18.3.2. **DUE**: Within three Business Days following the initial discovery of the Fraud or suspected Fraud

1.18.4. Contractor shall revise or provide additional information related to Contractor Suspected Fraud Written Notice Form as requested by the Department.

1.18.4.1. **DELIVERABLE**: Contractor Suspected Fraud Written Notice Revisions and Additional Information

1.18.4.2. **DUE**: Within three Business Days following the Department's request, unless the Department provides for a different period in its request.

2. CONTRACTOR PERSONNEL

2.1. Personnel General Requirements

2.1.1. Contractor shall possess the organizational resources and commitment necessary to perform the Work and successfully implement and operate the ACC in Contractors region. Specifically, Contractor shall:

2.1.1.1. Have a physical office located in Contractor's assigned region, unless otherwise approved by the Department in writing.

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

2.1.2. Contractor shall provide qualified Key Personnel and Other Personnel as necessary to perform the Work throughout the term of the Contract.

2.1.2.1. Take into consideration the community and the members it serves when hiring its Key

Personnel and Other Personnel.

2.1.2.2. Contractor shall provide the Department with a final list of individuals assigned to the Contract and appropriate contact information for those individuals, including relevant management/supervisory staff assigned to the Contract.

2.1.2.2.1. **DELIVERABLE**: Final list of individuals assigned to the Contract

2.1.2.2.2. **DUE**: Within five Business Days after the Effective Date

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

2.1.2.3.1. **DELIVERABLE**: Updated list of individuals assigned to the Contract

2.1.2.3.2. **DUE**: Within five Business Days after the Department's request for an update

2.1.3. Contractor shall not permit any individual proposed for assignment to Key Personnel positions to perform any Work prior to the Department's approval of that individual to be assigned as Key Personnel.

2.1.4. Contractor shall not voluntarily change individuals in Key Personnel positions without the prior written approval of the Department. Contractor shall supply the Department with the name, resume and references for any proposed replacement whenever there is a change to Key Personnel. 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.

2.1.4.1. **DELIVERABLE**: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change

2.1.4.2. **DUE**: At least five Business Days prior to the change in Key Personnel

2.1.5. If any individual filling a Key Personnel position leaves employment with Contractor, Contractor shall propose a replacement person to the Department. The replacement person 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.

2.1.5.1. **DELIVERABLE**: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position who leaves employment with Contractor

2.1.5.2. **DUE**: Within 10 Business Days after Contractor's receipt of notice that the person is leaving employment, unless the Department allows for a longer time in writing for Contractor to recruit a replacement.

2.1.6. 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 submit copies of such current licenses and certifications to the Department.

2.1.6.1. **DELIVERABLE**: All current professional licensure and certification documentation as specified for Key Personnel or Other Personnel

2.1.6.2. **DUE**: Within five Business Days of receipt of updated licensure or upon request by the Department

2.1.7. Contractor shall follow a Department approved process to request a specific Key Personnel be exempt from the requirement to be located in Colorado as specified in the Work.

2.1.8. Contractor shall provide the Department with an Organizational Chart listing all positions within Contractor's organization and Subcontracted organizations 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.

2.1.8.1. Contractor's Organizational Chart shall clearly communicate the following information at a minimum:

2.1.8.1.1. Contractor's executive leadership structure and reporting arrangements.

2.1.8.1.2. Contractor's Care Coordination staffing structure, including Subcontracted and delegated organizations, Member to care coordinator FTE ratio, and any specialized Care Coordination services offered.

2.1.8.1.3. The employer for the position, including owning entities, wholly-owned subsidiary organizations, and Subcontracted organizations.

2.1.8.1.3.1. **DELIVERABLE**: Organizational Chart.

2.1.8.1.3.2. **DUE**: Five Business days after the Effective Date.

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

2.1.8.2.1. **DELIVERABLE**: Updated Organizational Chart

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

2.2. Personnel Availability

2.2.1. Contractor shall ensure Key Personnel and Other Personnel assigned to the Contract are available for meetings with the Department during the Department's normal business hours, as determined by the Department. Contractor shall also make these personnel available outside of the Department's normal business hours and on weekends with prior notice from the Department.

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

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

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

2.2.5. All of Contractor's Key Personnel and Other Personnel that attend any meeting with the Department or other Department stakeholders that is scheduled to be in person 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.

2.2.6. Contractor shall respond to all telephone calls, voicemails, and emails from the Department within two Business Days of receipt by Contractor.

2.3. Key Personnel

2.3.1. Contractor shall designate people to hold the following Key Personnel positions:

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

2.3.1.1.1. The Program Officer shall:

2.3.1.1.1.1. Be located in Colorado.

2.3.1.1.1.2. Have senior management decision-making authority regarding the Contract.

2.3.1.1.1.3. Serve as Contractor's primary point of contact for the Contract and for Contract performance. The Program Officer shall work out of an office within Contractor's assigned region, unless otherwise approved by the Department in writing or Contractor chooses to have a Regional Contract Manager.

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

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

2.3.1.1.1.6. 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.

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

2.3.1.1.2. The Program Officer shall have the following qualifications:

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

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

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

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

2.3.1.2.1. The CFO shall:

2.3.1.2.1.1. 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.

2.3.1.2.1.2. 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.

2.3.1.2.1.3. Ensure financial compliance with federal and state laws as well as any applicable requirements.

2.3.1.2.2. The CFO shall have the following qualifications:

2.3.1.2.2.1. Licensed as certified public accountant or have a master's degree in accounting or business administration, unless otherwise approved by the Department in writing.

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

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

2.3.1.3.1. The CCO shall:

2.3.1.3.1.1. Be located in Colorado.

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

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

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

2.3.1.3.2. The CCO shall have the following qualifications:

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

2.3.1.3.2.2. Have a minimum of five years' experience within the last ten years working at a management level with Medicaid programs spanning both physical and behavioral health.

2.3.1.3.2.3. Have knowledge and experience with health care delivery system reform, addressing the health-related social needs and establishing coverage policies based on evidence-based practices.

2.3.1.4. Chief Behavioral Health Officer – One full-time employee. The Chief Behavioral Health Officer shall be a senior management position.

2.3.1.4.1. The Chief Behavioral Health Officer shall:

2.3.1.4.1.1. Be located in Colorado.

2.3.1.4.1.2. Collaborate with the CCO to define the clinical vision for Contractor's Behavioral Health program and PIHP.

2.3.1.4.1.3. Provide clinical direction to the Behavioral Health network management, quality improvement, utilization management and credentialing activities.

2.3.1.4.1.4. Provide clinical oversight, expertise and leadership to ensure the establishment of a comprehensive continuum of Behavioral Health services and the delivery of coordinated, cost-effective Behavioral Health services and supports for Members.

2.3.1.4.1.5. Participate in strategic development and implementation of the State of Colorado's vision for Behavioral Health, in collaboration with the Department and the Behavioral Health Administration.

2.3.1.4.2. The Chief Behavioral Health Officer shall have the following qualifications:

2.3.1.4.2.1. Be a licensed Behavioral Health clinician, board-certified psychiatrist or physician with board certification in addiction medicine.

2.3.1.4.2.2. Be licensed to practice in the State of Colorado.

2.3.1.4.2.3. Have a minimum of five years of experience within the last ten years working at a management level in managed Behavioral Health care.

2.3.1.4.2.4. Have experience in practice or in administration of community-based Behavioral Health services for individuals with serious mental illness and serious emotional disturbance.

2.3.1.4.2.5. Have experience in practice or in administration of the integration of care across medical and Behavioral Health Providers

2.3.1.5. Health Equity Officer – One full- time employee. The Health Equity Officer shall be a senior leadership position.

2.3.1.5.1. The Health Equity Officer shall:

2.3.1.5.1.1. Be located in Colorado.

2.3.1.5.1.2. Be accountable for Contractor's programming, staff training, and related activities regarding disability accessibility, cultural competency and effective communication.

2.3.1.5.1.3. Serve as Contractor's point of contact on health equity for region with the Department.

2.3.1.5.1.4. Represent region in Department-led meetings regarding equity, as well as attend any other Department requested meetings.

2.3.1.5.1.5. Design, implement, and operate Contractor's health equity programs by setting milestones, goals, and priorities. Examples of these shall include, but not be limited to the following:

2.3.1.5.1.5.1. Program metrics and analytics.

2.3.1.5.1.5.2. Strategic and tactical short and long-term plans.

2.3.1.5.1.5.3. Communications.

2.3.1.5.1.6. Monitor Data trends and demographics data via Contractor's health equity dashboard.

2.3.1.5.1.7. Perform research into programs, operations, and best practices to develop and execute a plan to integrate health equity practices of cultural and disability responsiveness into Contractor's daily business with the goal of improving the health of Contractor's Members, while simultaneously closing healthcare disparities.

2.3.1.5.1.8. Coordinate, connect and facilitate training opportunities for Contractor staff.

2.3.1.5.2. The Health Equity Officer shall have the following qualifications:

2.3.1.5.2.1. Experience within the last five years in the public/community health education or engagement, health disparity research, and/or health equity programming and facilitation.

2.3.1.5.2.2. At least a bachelor's degree in health sciences, human resources, or in a closely related field/focus that has prepared the candidate for work with health disparities and health equity work. Masters level preferred.

2.3.1.5.2.3. Knowledge and experience in the following areas:

2.3.1.5.2.3.1. Complex practices, issues, and theoretical principles related to health equity and disparities.

2.3.1.5.2.3.2. Contemporary multicultural communication and engagement concepts and issues within the healthcare field.

2.3.1.5.2.3.3. Principles and practices related to developing and implementing health improvement strategies to address health related social needs.

2.3.1.5.2.3.4. Medicaid programs, entitlement programs, and related regulations.

2.3.1.5.2.3.5. Ability to act as an internal resource and consultant, working collaboratively with multiple stakeholders in a politically sensitive context complicated by competing perspectives and interests

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

2.3.1.6.1. The Quality Improvement Director shall:

2.3.1.6.1.1. Be located in Colorado.

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

2.3.1.6.1.3. Direct and coordinate all quality improvement activities.

2.3.1.6.1.4. Ensure alignment with federal and state guidelines.

2.3.1.6.1.5. Set internal performance goals and objectives.

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

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

2.3.1.6.2.2. Minimum of five years of professional experience in healthcare quality improvement within the last ten years.

2.3.1.6.2.3. Knowledge and Experience in the following areas:

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

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

2.3.1.6.2.3.3. Compliance and regulation enforcement.

2.3.1.7. Health Information Technology (HIT) and Data Director – One full-time employee.

2.3.1.7.1. The HIT and Data Director shall:

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

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

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

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

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

2.3.1.7.1.5.1. Client enrollment spans.

2.3.1.7.1.5.2. Capitation payments.

2.3.1.7.1.5.3. Encounter Data.

2.3.1.7.1.5.4. Health needs survey information.

2.3.1.7.1.5.5. Admission, discharge, and transfer data.

2.3.1.7.1.5.6. EDW and PPQM System data.

2.3.1.7.1.5.7. SHIE System data.

2.3.1.7.2. The HIT and Data Director shall have the following qualifications:

2.3.1.7.2.1. Experience directing a health information technology program.

2.3.1.7.2.2. Experience supporting health care practices.

2.3.1.7.2.3. Expertise in health data analytics.

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

2.3.1.8.1. The Utilization Management Director shall:

2.3.1.8.1.1. Be located in Colorado.

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

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

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

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

2.3.1.8.2.1. Registered Nurse or equivalent health care professional with necessary Behavioral Health clinical experience and medical knowledge.

2.3.1.8.2.2. Minimum of five years' cumulative experience in utilization management and managed care within the past ten years.

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

2.3.1.9. Director of Care Coordination– One full-time employee.

2.3.1.9.1. The Director of Care Coordination shall:

2.3.1.9.1.1. Be located in Colorado.

2.3.1.9.1.2. Oversee the design, implementation and operational management of all Care Coordination requirements as outlined in Section 8.

2.3.1.9.1.3. Facilitate effective communication, collaboration, and coordination between Contractor and, at a minimum, partner CMAs, BHASOs, and D-SNPs with the goal of ensuring comprehensive, effective and efficient coordination of care for jointly managed Members.

2.3.1.9.1.4. Manage Care Coordination processes and staff.

2.3.1.9.1.5. Oversee effective delivery of Care Coordination for Members by Network Providers, delegated and Subcontracted organizations, and others within the Health Neighborhood.

2.3.1.9.1.6. Build and nurture trusted and cooperative working relationships with all partner CMAs, BHASOs, and D-SNPs.

2.3.1.9.1.7. Create proactive processes and policies to prevent the exacerbation of Member conditions and the escalation of Member situations.

2.3.1.9.2. The Director of Care Coordination shall have the following qualifications:

2.3.1.9.2.1. Registered Nurse, master's level social worker or equivalent health care professional with necessary clinical experience.

2.3.1.9.2.2. Minimum of five years' cumulative experience in Care Coordination and case management within the past ten years.

2.3.1.9.2.3. Knowledge of Medicare and coordinating care for individuals with disabilities.

2.3.1.10. Child and Youth System of Care Manager – One full-time employee.

2.3.1.10.1. The Child and Youth System of Care Manager shall:

2.3.1.10.1.1. Be located in Colorado.

2.3.1.10.1.2. Serve as Contractor's primary point of contact for the Child and Youth Medicaid System of Care (MSOC).

2.3.1.10.1.3. Participate in Department-led meetings regarding the Settlement Agreement and implementation of the MSOC.

2.3.1.10.1.4. Work with Contractor's Utilization Management Director, Director of Care Coordination, and other personnel on implementation and operations of the MSOC.

2.3.1.10.1.5. Serve as point of contact for Care Coordinators serving MSOC Members.

2.3.1.10.2. The Child and Youth System of Care Manager shall have the following qualifications:

2.3.1.10.2.1. Licensed mental health professional or equivalent health care professional with necessary clinical experience with children, youth and families.

2.3.1.10.2.2. Minimum of five years' cumulative experience in mental health service delivery or Care Coordination with children, youth and families.

2.3.1.10.2.3. Knowledge of and experience with High-Fidelity Wraparound and child and youth Systems of Care.

2.3.1.10.2.4. Knowledge of and experience with Medicaid programs.

2.3.1.11. Regional Contract Manager – One full-time employee.

2.3.1.11.1. The Regional Contract Manager shall:

2.3.1.11.1.1. Be located in Colorado.

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

2.3.1.11.1.3. Report directly to the Program Officer.

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

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

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

2.3.1.11.1.7. Work out of an office within Contractor's assigned region.

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

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

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

2.3.1.11.2.3. Knowledge of and experience with Medicaid programs.

2.3.1.12. Contractor shall ensure appropriate administrative expertise in Behavioral Health among its Key Personnel.

2.3.1.13. Contractor shall require Department approval to fill a Key Personnel position with an individual(s) not directly employed by the Contracted entity.

2.3.2. Contractor is responsible for maintaining a significant local presence within the State of Colorado. Positions performing functions related to this Contract must have a direct reporting relationship to the local Program Officer. The local Program Officer shall have the authority to direct, implement, and prioritize work to ensure compliance with Contract requirements. The local Program Officer shall have the authority and ability to prioritize and direct work performed by Contractor staff and work performed under this Contract through a management service agreement or through a delegated agreement.

2.3.3. Contractor shall not allow for any individual to fill more than one of the roles defined as Key Personnel.

2.4. Other Personnel Responsibilities

2.4.1. 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. If the Department determines 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.

2.4.2. Contractor shall have sufficient staff dedicated to specifically to and working exclusively on the following Work activities:

2.4.2.1. Provider contracting.

2.4.2.2. Provider support regarding processing of claims.

2.4.2.3. Responding to and resolving Provider Grievances.

2.4.2.4. Care Coordination.

2.4.3. 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.

2.4.4. Contractor shall ensure that all Personnel receive training at least one time annually on topics related to disability and cultural competency and communication that must include but are not limited to the following:

2.4.4.1. Nondiscrimination.

2.4.4.2. Working with Members of different abilities.

2.4.4.3. Working with Members who speak English as a second language.

2.4.5. Contractor may subcontract to complete a portion of the Work required by the Contract. The conditions for using a Subcontractor or Subcontractors are as follows:

2.4.5.1. Contractor shall not subcontract more than 40% of the Work.

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

2.4.5.3. Contractor shall ensure any subcontracted or delegated entity/Provider meets Performance Standards and reporting requirements set forth in this Contract

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

2.4.5.3.2. **DUE**: The later of 30 days prior to the Subcontractor beginning work or the Effective Date

2.4.5.4. Contractor shall not Subcontract any of the responsibilities in the Work regarding, responding to and resolving Provider complaints.

2.4.5.5. Contractor shall require all Subcontractors who have direct contact with Members or Network Providers to follow the Department branding standards and to use the same organizational name as Contractor when directly communicating with Members and Network Providers to prevent confusion.

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

3. ADMINISTRATIVE REPORTING REQUIREMENTS

3.1. Contractor shall provide all reports listed in this section in the format directed by the Department and containing the information requested by the Department.

3.2. Administrative Reporting

3.2.1. Contractor shall provide an Administrative Report to the Department, upon the Department's request, covering the period directed by the Department.

3.2.1.1. The Administrative Report shall contain all information regarding Contractor's staffing, expenses and revenues relating to the Work, as directed by the Department for the period

that the report covers. This information may include, but is not limited to, all of the following:

3.2.1.1.1. Number of Full Time Equivalent per position category, as determined by the Department, and total salary expenditure for that position category.

3.2.1.1.2. Operating expenses broken out by category, as determined by the Department.

3.2.1.1.3. Number of staff that were newly hired and separated and number of vacant positions, broken out by position category, as determined by the Department.

3.2.1.1.4. Administrative revenues, such as payments by debt and interest revenues, broken out by source as directed by the Department.

3.2.1.1.5. Administrative expenditures, such as payments to Subcontractors and Providers, broken out by source as directed by the Department.

3.2.1.1.6. Remaining cash-on-hand at the end of the period.

3.2.1.2. Contractor shall deliver the Administrative Report to the Department within 10 Business Days following the request by the Department for that report. The Department may create a fixed schedule for Contractor's submission of the Administrative Report by delivering the schedule to Contractor in writing. The Department may change or terminate any fixed schedule it creates by notifying Contractor in writing of the change or termination.

3.2.1.2.1. **DELIVERABLE**: Administrative Report

3.2.1.2.2. **DUE**: Within 10 Business Days after the Department's request. If the Department has delivered a fixed schedule to Contractor, then Contractor shall deliver the report as described in the most recent version of that schedule.

4. INFORMATION TECHNOLOGY RELATED REQUIREMENTS

4.1. Protection of System Data

4.1.1. 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.

4.1.2. 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:

4.1.2.1. Contractor provides physical or logical storage of State Records.

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

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

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

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

4.1.3.2. 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.

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

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

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

4.1.4. Colorado Information Security Policy (CISP) Compliance

4.1.4.1. 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.

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

4.1.4.3. 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.

4.1.4.3.1. **DELIVERABLE**: CISP Attestation

4.1.4.3.2. **DUE**: Within 30 Business Days after the Effective Date

4.1.4.4. 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.

4.1.4.4.1. **DELIVERABLE**: Annual CISP Attestation

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

4.1.4.5. 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.

4.1.5. Health and Human Services HIPAA Security Rule Risk Assessments

4.1.5.1. Contractor shall deliver to the State a signed Initial 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.

4.1.5.1.1. **DELIVERABLE**: Initial HHS Attestation

4.1.5.1.2. **DUE**: Within 30 Business Days after the Effective Date

4.1.5.2. 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 Annual HHS Attestation, on a form provided by the Department.

4.1.5.2.1. **DELIVERABLE**: Annual HHS Attestation

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

4.1.5.3. 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.

4.1.6. 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.

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

4.1.7.1. 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.

4.1.7.1.1. **DELIVERABLE**: Background Check Attestation

4.1.7.1.2. **DUE**: Within 30 Business Days of the Effective Date

4.1.7.2. 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.

4.2. Data Handling

4.2.1. 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.

4.2.2. 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.

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

4.2.4. The State retains the right to use the established operational services to access and retrieve State Records stored on Contractor's infrastructure at its sole discretion and at any time. Upon request of the State or of the supervisory authority, Contractor shall submit its data processing facilities for an audit of the measures referred to in this Exhibit in accordance with the terms of this Contract.

EXHIBIT F, SAMPLE OPTION LETTER

State Agency
Department of Health Care Policy and Financing

Contractor
Insert Contractor's Full Legal Name, including "Inc.", "LLC", etc.

Option Letter Number
Insert the Option Number (e.g. "1" for the first option)

Original Contract Number
Insert CMS number or Other Contract Number of the Original Contract

Option Contract Number
Insert CMS number or Other Contract Number of this Option

Contract Performance Beginning Date
Month Day, Year

Current Contract Expiration Date
Month Day, Year

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**

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 Contract rates

E. Option to initiate next phase of the Contract

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 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:

The effective date of this Option Letter is upon approval of the State Controller or Month Day, Year, whichever is later.

STATE OF COLORADO
Jared S. Polis, Governor
Department of Health Care Policy and Financing
Kim Bimestefer, Executive Director

Date: _____

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD
Department of Health Care Policy and Financing
Jerrod Cotosman, Controller, or authorized delegate

Option Effective Date: _____

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

EXHIBIT G, CONTRACT FEDERAL PROVISIONS

1. Applicability of Provisions.

A. The Contract or Purchase Order to which these Federal Provisions are attached has been funded, in whole or in part, with an Award of Federal funds. In the event of a conflict between the provisions of these Federal Provisions, the Special Provisions, the body of the Contract or Purchase Order, or any attachments or exhibits incorporated into and made a part of the Contract or Purchase Order, the provisions of these Federal Provisions shall control.

2. Compliance.

A. Contractor shall comply with all applicable provisions of the Transparency Act, all applicable provisions of the Uniform Guidance, and the regulations issued pursuant thereto, including but not limited to these federal Provisions. Any revisions to such provisions or regulations shall automatically become a part of these Federal Provisions, without the necessity of either party executing any further instrument. The State of Colorado may provide written notification to Contractor of such revisions, but such notice shall not be a condition precedent to the effectiveness of such revisions.

3. System for Award Management (SAM) and UNIQUE ENTITY ID Requirements.

A. SAM. Contractor shall maintain the currency of its information in SAM until the Contractor submits the final financial report required under the Award or receives final payment, whichever is later. Contractor shall review and update SAM information at least annually after the initial registration, and more frequently if required by changes in its information.

B. Unique Entity ID. Contractor shall provide its Unique Entity ID to its Recipient, and shall update Contractor's information at http://www.sam.gov at least annually after the initial registration, and more frequently if required by changes in Contractor's information.

4. Contract Provisions Required by Uniform Guidance Appendix II to Part 200.

A. **Contracts for more than the simplified acquisition threshold**, which is the inflation adjusted amount determined by the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) as authorized by 41 U.S.C. 1908, must address administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provide for such sanctions and penalties as appropriate. The simplified acquisitions threshold is $250,000

B. **All contracts in excess of $10,000 must address termination for cause and for convenience** by the non-Federal entity including the manner by which it will be effected and the basis for settlement.

C. **Equal Employment Opportunity**. Except as otherwise provided under 41 CFR Part 60, all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3 must include the equal opportunity clause provided under 41 CFR 60-1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964-1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 relating to Equal Employment Opportunity," and implementing regulations at 41 CFR Part 60, "Office of federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

D. **Davis-Bacon Act**, as amended (40 U.S.C. 3141-3148). When required by Federal program legislation, all prime construction contracts in excess of $2,000 awarded by non-Federal entities must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors must be required to pay wages not less than once a week. The non-Federal entity must place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation. The decision to award a contract or subcontract must be conditioned upon the acceptance of the wage determination. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency. The contracts must also include a provision for compliance with the Copeland "Anti-Kickback" Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or subrecipient must be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency.

E. **Contract Work Hours and Safety Standards Act** (40 U.S.C. 3701-3708). Where applicable, all contracts awarded by the non-Federal entity in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, each contractor must be required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

F. **Rights to Inventions Made Under a Contract or Agreement**. If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

G. **Clean Air Act (42 U.S.C. 7401-7671q.) and the federal Water Pollution Control Act (33 U.S.C. 1251-1387),** as amended - Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the non-Federal award to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

H. **Debarment and Suspension** (Executive Orders 12549 and 12689) - A contract award (see 2 CFR 180.220) must not be made to parties listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

I. **Byrd Anti-Lobbying Amendment** (31 U.S.C. 1352) - Contractors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non-Federal award.

J. Prohibition on certain telecommunications and video surveillance services or equipment §2 CFR 200.216

i. Recipients and sub recipients are prohibited from obligating or expending loan or grant funds to:

a. Procure or obtain;

b. Extend or renew a contract to procure or obtain; or

c. Enter into a contract (or extend a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

K. **Contracts with small and minority businesses, women's business enterprises, and labor surplus area firms. (2 CFR §200.321).** The non-Federal entity must take all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

L. **Domestic preferences for procurements**. (2 CFR §200.322) As appropriate and to the extent consistent with law, the non-Federal entity should, to the greatest extent practicable under a Federal award, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States (including but not limited to iron, aluminum, steel, cement, and other manufactured products). The requirements of this section must be included in all subawards including all contracts and purchase orders for work or products under this award.

M. **Procurement of recovered materials**. (2 CFR §200.323) A non-Federal entity that is a state agency or agency of a political subdivision of a state and its contractors must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding Fiscal Year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

5. Event of Default.

A. Failure to comply with these Federal Provisions shall constitute an event of default under the Contract and the State of Colorado may terminate the Contract upon 30 days prior written notice if the default remains uncured five calendar days following the termination of the 30 day notice period. This remedy will be in addition to any other remedy available to the State of Colorado under the Contract, at law or in equity

EXHIBIT H, PII CERTIFICATION

STATE OF COLORADO
THIRD PARTY ENTITY / ORGANIZATION CERTIFICATION FOR ACCESS TO PII THROUGH A DATABASE OR AUTOMATED NETWORK

Pursuant to § 24-74-105, C.R.S., I, Patrick Gordon, on behalf of Rocky Mountain HMO, Inc. (legal name of entity / organization) (the "Organization"), hereby certify under the penalty of perjury that the Organization has not and will not use or disclose any Personal Identifying Information, as defined by § 24-74-102(1), C.R.S., for the purpose of investigating for, participating in, cooperating with, or assisting Federal Immigration Enforcement, including the enforcement of civil immigration laws, and the Illegal Immigration and Immigrant Responsibility Act, which is codified at 8 U.S.C. §§ 1325 and 1326, unless required to do so to comply with Federal or State law, or to comply with a court-issued subpoena, warrant or order.

I hereby represent and certify that I have full legal authority to execute this certification on behalf of the Organization.

Signature: DocuSigned by: 35A5356F969D46D...

Printed Name: Patrick Gordon

Title: CEO

Date: 03/11/2025 | 17:04 PDT

EXHIBIT I, SUBSTANCE USE DATA

1. As part of this Contract the Department will provide the Contractor with Part 2 Data for enrolled Members as defined under 42 CFR Part 2. The Contractor shall handle all Part 2 Data in conformity with the requirements of 42 CFR Part 2 And 42 CFR § 2.33, Those requirements include, but are not limited to, the following:

1.1. The Contractor shall use Part 2 Data only for the following two (2) purposes:

1.1.1. rate setting, reconciliation analyses, along with payment reform projects.

1.1.2. ad hoc projects like performance metrics development, audit review and actuarial consulting services.

1.2. The Contractor shall not use the Part 2 Data for any other purpose, to include care coordination or case management, without appropriate consent as defined under 42 CFR Part 2.

1.3. The Contractor upon receipt of Part 2 Data shall:

1.3.1. Not disclose Part 2 data without appropriate consent except as permitted under 42 CFR Part 2 and 42 CFR § 2.33

1.3.2. Create safeguards, including documented policies and procedures, to prevent unauthorized uses and disclosures of Part 2 Data. These policies and procedures shall be reported in the Contractors' Data Governance Policy.

1.3.3. Immediately report any unauthorized use, disclosures, or breaches of Part 2 Data to the Department.

1.4. The Contractor only shall redisclose Part 2 Data to a third part if the third part is a contract agent of the Contractor helping to perform its' duties under the Contract and the contract agent only discloses Part 2 Data back to the Contractor or the Department.

1.5. If the Contractor obtains Member consent to disclose Part 2 Data the Contractor may disclose the part 2 Data in accordance with the consent to any person or category of persons identified or generally designated in the consent, except that disclosure to central registries and in connection with criminal justice referrals shall meet the requirements of 42 CFR § 2.34 and 42 CFR § 2.35.

1.6. If the Contractor obtains Member consent to disclose Part 2 Data for payment or health care operations activities a lawful holder who receives such data may further disclose that data as may be necessary for the lawful holders' contractors, subcontractor or legal representatives to carry out payment or health care operations on behalf of such lawful holder. Part 2 Data disclosures shall be limited to the information necessary to carry out the stated purpose of the Members' disclosure.

Exhibit J, RAE REGION 4 AND DENVER HEALTH MEDICAID CHOICE

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EXHIBIT K, CAPITATED BEHAVIORAL HEALTH BENEFIT COVERED SERVICES AND 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.

A covered diagnosis is not required for services with a primary category of Assessment, Screening, Crisis, or Prevention/Intervention, as indicated in the State Behavioral Health Services billing manual.

Starting January 1, 2024, the Contractor shall be responsible for covering psychotherapy services (90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, and 90853) with a primary diagnosis of Autism Spectrum Disorder ((F84.0-F84.9) for Members under the age of 21.

Specialty Behavioral Health Codes

00104	Anesthesia for ECT
90785	Interactive Complexity*
90832	Psychotherapy-30 mins
90833	Psytx pt &/or family w/e&m 30 mins
90834	Psychotherapy-45 mins
90836	Psytx pt &/or family w/e&m 45 mins
90837	Psychotherapy-60 mins
90838	Psytx pt &/or family w/e&m 60 mins
90839	Psychotherapy for crisis, first 60 mins
90839 ET	Mobile Crisis Response, 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 30mins
90876	Indv Psychotherapy biofeedback 45mins
96372	Ther/proph/diag inj, sc/im
97535	Self-care management training
97537	Community/work reintegration
G0176	Activity therapy 45 mins 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
H0039	Assertive Comm treatment per 15mins
H0035	MH Partial Hospitalization less 24 hrs.
H0036	Comm psych treatment per 15 mins
H0036 +HA	Functional Family Therapy (FFT) or Community Psychiatric Supportive Treatment (CPST), per 15 mins.
H0037	Comm psych supportive treatment, per diem
H0037 +HA	FFT or CPST, per diem
H0038	Self-help/peer services per 15 mins
H0039	Assertive Comm treatment, per 15 mins
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 mins
H2015	Comprehen comm support per 15 mins
H2016	Comprehen comm support, per diem
H2017	Psysoc rehab svc, per 15 mins
H2018	Psysoc rehab svc, per diem
H2021	Com wrap-around sv, 15 mins
H2022	Com wrap-around sv, per diem
H2023	Supported employ, per 15 mins
H2024	Supported employ, per diem
H2025	Supp maint employ, 15 mins
H2026	Supp maint employ, per diem
H2027	Psycho ed service, per 15 mins

H0010 Clinically managed residential withdrawal management: ASAM level 3.2WM, per diem	H2030 MH clubhouse per 15 mins
H0011 Clinically managed residential withdrawal management: ASAM level 3.7WM, per diem	H2031 MH clubhouse per diem
H0015 Alcohol/Drug intensive outpatient	H2032 Activity therapy per 15 mins
H0016 Alcohol/Drug service; partial hospitalization program	H2033 Multisys ther/juvenile 15 mins
H0017 BH residential w/o room/board, Acute Treatment Unit	H2036 +U1 ASAM level 3.1 - Clinically managed low-intensity residential services, per diem
H0018 BH short term res w/o room/board, Crisis Stabilization Unit	H2036 + U3 ASAM level 3.3 - Clinically managed population-specific high-intensity residential services, per diem
H0019 +U1 Qualified Residential Treatment Program (QRTP). Behavioral Health; long term residential, without room and board, per diem	H2036 +U5 ASAM level 3.5 - Clinically managed high-intensity residential services, per diem
H0019 +HB Adult Mental Health Transitional Living; long-term residential, without room and board, per diem	H2036 +U7 ASAM level 3.7 - Medically monitored intensive inpatient services, per diem
H0020 Methadone admin/service	S5150 Unskilled respite care, per 15 mins
H0033 Oral med admin observation	S5151 Unskilled respite care, per diem
H0034 Med training/support per 15 mins	S9445 Patient ed non-phys, indv
	S9480 Intens Outpatient psych per diem
	S9485 Crisis Interv MH per diem
	T1005 Respite care service 15 mins
	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	H0023 BH outreach/Drop in
90792 Diagnostic Eval with Medical Service	H0025 BH prevention education
90887 Interpretation/explanation of psych/medical exam/data	H0030 BH Crisis Hotline
96116 Neurobehavioral status exam; first hr	H0031 MH assessment by non-phys
96121 Neurobehavioral status exam; add'lhrs**	H0032 MH service plan devel bynon-phys
96130 Psych testing eval services; first hr	H0046 Drop-in Center
96131 Psych testing eval services; add'l hrs**	H2000 Comprehensive multidiscipline edu
96132 Neuropsych testing eval services; first hr	H2011 Crisis intervention per 15 mins
96133 Neuropsych testing eval services; add'l hrs**	H2011 ET Mobile Crisis Response, each additional 15 mins
96136 Psych or neuropsych test admin & scoring; 30 mins	S9453 Smoking cess class, non-phys, per ses
96137 Psych or neuropsych test admin; add'l 30 mins**	S9454 Stress manage, non-phys, per ses
96138 Psych or neuropsych test admin, by tech; first 30 mins	A0999 BHST One-way trip

96139	Psych or neuropsych test admin, by tech; add'l 30 mins**	A0425	BHST ground mileage, per mile
96146	Psych or neuropsych test - automated		
98966	Hc pro phone call 5-10 mins		
98967	Hc pro phone call 11-20 mins		
98968	Hc pro phone call 21-30 mins		
H0001	Alcohol and/or drug assessment		
H0002	Alcohol and/or drug screening		

Reimbursed under the Behavioral Health capitation when the service is provided for a covered Behavioral Health diagnosis, regardless of the billing provider.			
Evaluation & Management Consultation Codes			
99242	Outpatient Consultation, at least 20 mins	99252	Hospital Consultation, at least 35 mins
99243	Outpatient Consultation, at least 30 mins	99253	Hospital Consultation, at least 45 mins
99244	Outpatient Consultation, at least 40 mins	99254	Hospital Consultation, at least 45 mins
99245	Outpatient Consultation, at least 55 mins	99255	Hospital Consultation, at least 80 mins
Evaluation & Management Emergency Department Codes			
99281	Emergency department visit for problem that may not require health care professional	99284	Emergency department visit with moderate level of medical decision making
99282	Emergency department visit with straightforward medical decision making	99285	Emergency department visit with high level of medical decision making
99283	Emergency department visit with low level of medical decision making		

Reimbursed through the behavioral health capitation for a covered Behavioral Health diagnosis when the service is billed by a Behavioral Health Specialty Provider.			
Evaluation & Management Codes			
99202	Office or OP – New, 15 – 29 mins	99307	Subseq nursing facility, 10 mins
99203	Office or OP – New, 30 – 44 mins	99308	Subseq nursing facility, 15 mins
99204	Office or OP – New, 45 – 59 mins	99309	Subseq nursing facility, 30 mins
99205	Office or OP – New, 60 – 74 mins	99310	Subseq nursing facility, 45 mins
99211	Office or OP – other	99315	Nursing facility discharge, 30 mins
99212	Office or OP – Est, 10 – 19 mins	99316	Nursing facility discharge, 30+ mins
99213	Office or OP – Est, 20 – 29 mins	99341	Residence visit – New, at least 15 mins
99214	Office of OP – Est, 30 – 39 mins	99342	Residence visit – New, 30 mins
99215	Office or OP – Est, 40 – 45 mins	99344	Residence visit – New, 60 mins
99221	Initial hospital care at least 40 mins	99345	Residence visit – New, 75 mins
99222	Initial hospital care at least 55 mins	99347	Residence visit – Est, 15 mins

99223	Initial hospital care at least 75 mins	99348	Residence visit – Est, 30 mins
99231	Subsequent hospital care at least 25 mins	99349	Residence visit – Est, 40 mins
99232	Subsequent hospital care at least 35 mins	99350	Residence visit – Est, 60 mins
99233	Subsequent hospital care at least 50 mins	99366	Team conf w/patient by hc pro
99234	Same day admit/DC, at least 45 mins	99367	Team conf w/o patient by phys.
99235	Same day admit/DC, at least 70 mins	99368	Team conf w/patient by hc pro
99236	Same day admit/DC, at least 85 mins		
99238	Hospital discharge day 30 mins or less		
99239	Hospital discharge more than 30 mins		
99304	Initial nursing facility, 25 mins		
99305	Initial nursing facility, 35 mins		
99306	Initial nursing facility,45 mins		

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 mins with pt and /or family mbr when performed with an E&M	90838	Psychotherapy, 60 mins with pt and /or family mbr when performed with an E&M
90833	Psychotherapy, 30 mins with pt and /or family mbr when performed with an E&M		

The following revenue codes (in addition to those represented in Appendix Q on the Department's website) may be covered under the capitated behavioral health benefit:	
0510	CLINIC PSYCHIATRIC CLINIC PSYCH CLINIC
0513	CLINIC PSYCHIATRIC CLINIC PSYCH CLINIC
0902	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENSION OF 090X) MILIEU THERAPY BEHAVIORAL HEALTH/MILIEU THERAPY
0903	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENTION OF 090X) PLAY THERAPY BEHAVIORAL HEALTH/PLAY THERAPY
0904	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENSION OF 090X) ACTIVITY THERAPY BEHAVIORAL HEALTH/ACTIVITY THERAPY
0905	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENSION OF 090X) INTENSIVE OUTPATIENT SERVICES – PSYCHIATRIC BEHAVIORAL HEALTH/INTENS OP/PSYCH*
0906	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X - AN EXTENSION OF 090X) INTENSIVE OUTPATIENT SERVICES - CHEMICAL DEPENDENCY BH/INTENS OP/CHEM DEP**
0907	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X - AN EXTENSION OF 090X) COMMUNITY BEHAVIORAL HEALTH PROGRAM (DAY TREATMENT) BH/COMMUNITY
0911	BEHAVIORAL HEALTH TREATMENT/SERVICES – EXTENSION OF 090X*** - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

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
1002	MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT
1003	BEHAVIORAL HEALTH ACCOMMODATIONS SUPERVISED LIVING*
1005	BEHAVIORAL HEALTH ACCOMMODATIONS GROUP HOME***

* For mental health diagnoses only

** For Substance Use Disorder (SUD) diagnoses only

*** For members under the age of 21

Behavioral Health Specialty Provider Types*		
Provider Type (PT)	*Specialty Type*	*Provider Type Description*
64	212	Substance Use Continuum ASAM 2.5 PHP
64	213	Substance Use Continuum Opioid Treatment Provider (OTP) – Moderate Risk
64	214	Substance Use Continuum Opioid Treatment Provider (OTP) – High Risk
64	371	Substance Use Continuum ASAM 1.0
64	372	Substance Use Continuum ASAM 1 WM
64	373	Substance Use Continuum ASAM 2.1 IOP
64	374	Substance Use Continuum ASAM 2WM
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
78	877	Comprehensive Community Behavioral Health Provider
88	880	Behavioral Health Crisis Line
89	889	Community Support Services Provider, Recovery Support Services Organization
89	208	Community Support Services Provider, Supportive Housing Provider
95	386	Crisis Provider, Crisis Stabilization Unit
95	387	Crisis Provider, Acute Treatment Unit
95	772	Crisis Provider, Mobile Crisis Response
96	561	Adult Mental Health Residential, Supported Therapeutic Transitional Living

* This table is only for providers that can bill for Evaluation and Management services. Exceptions are Consultation Codes (99242 - 99245, 99252-99255) and ED codes 99281-99285

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Covered SUD Diagnoses

Covered SUD Diagnoses

ICD-10-CM Code Ranges

Start	End
F10.10	F19.99

Covered MH Diagnoses

ICD-10-CM Code Ranges

Start	End
F20.0	F69
F90.0	F98.4
F98.8	F99
R45.1	R45.2
R45.5	R45.82

Covered Social Determinants of Health (SDOH) Diagnoses for Members Under 21 when billing services under SB23-174 Coverage
(See Appendix I for codes highlighted in BLUE)

Start	End	Start	End
R45.0	R45.7	Z60.0	Z60.9
R45.81	R45.84	Z62.0	Z62.1
R45.850	R45.89	Z62.21	Z62.6
R69 and Z03.89		Z62.810	Z62.819
Z55.0	Z55.9	Z62.820	Z62.823
Z56.0	Z56.6	Z62.831	Z62.833
Z56.81	Z56.9	Z62.890	Z62.9
Z58.81	Z58.9	Z63.0	Z63.1
Z59.00	Z59.02	Z63.31	Z63.6
Z59.10	Z59.3	Z63.71	Z63.9
Z59.41	Z59.7	Z64.0	Z64.4
Z59.811	Z59.9	Z65.0	Z65.9

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EXHIBIT L, COUNTY POPULATION AND DENSITY PARAMETERS

The county type, Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC), is a significant component of the network access criteria. The Centers for Medicare and Medicaid Services (CMS) uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Density parameters are foundationally based on approaches taken by the U.S. Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the Office of Management and Budget (OMB) in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with population greater than one million and a density greater than or equal to 1,000 persons per square mile (sq. mile) is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated "Large Metro" if any of the three Large Metro population-density combinations listed in the following table are met; a county is designated as "Metro" if any of the five Metro population-density combinations listed in the table are met; etc.).

County Type	Population	Density
Large Metro	≥1,000,000	≥1,000/sq. mile
---	500,000 – 999,999	≥1,500/sq. mile
---	Any	≥5,000/sq. mile
Metro	≥1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9/sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

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1.1. COLORADO COUNTY DESIGNATIONS

County	Classification
Adams	Metro
Alamosa	Rural
Arapahoe	Metro
Archuleta	Rural
Baca	CEAC
Bent	CEAC
Boulder	Metro
Broomfield	Metro
Chaffee	Rural
Cheyenne	CEAC
Clear Creek	Rural
Conejos	CEAC
Costilla	CEAC
Crowley	CEAC
Custer	CEAC
Delta	Rural
Denver	Large Metro
Dolores	CEAC
Douglas	Metro
Eagle	Micro
Elbert	Rural
El Paso	Metro
Fremont	Rural
Garfield	Micro
Gilpin	Rural
Grand	CEAC

Gunnison	CEAC
Hinsdale	CEAC
Huerfano	CEAC
Jackson	CEAC
Jefferson	Metro
Kiowa	CEAC
Kit Carson	CEAC
Lake	Rural
La Plata	Micro
Larimer	Metro
Las Animas	CEAC
Lincoln	CEAC
Logan	Rural
Mesa	Micro
Mineral	CEAC
Moffat	CEAC
Montezuma	Rural
Montrose	Rural
Morgan	Rural
Otero	Rural
Ouray	CEAC
Park	CEAC
Phillips	CEAC
Pitkin	Rural
Prowers	CEAC
Pueblo	Micro
Rio Blanco	CEAC
Rio Grande	Rural
Routt	Rural

Saguache	CEAC
San Juan	CEAC
San Miguel	CEAC
Sedgwick	CEAC
Summit	Micro
Teller	Rural
Washington	CEAC
Weld	Metro
Yuma	CEAC

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EXHIBIT M, MANAGED CARE ORGANIZATION STATEMENT OF WORK

1. MANAGED CARE ORGANIZATION

1.1. Contractor shall provide the managed care services for physical health as described in this Exhibit M, for the Member population enrolled in Contractor's limited managed care capitation initiative (also referred to as Managed Care Organization or MCO); the Behavioral Health managed care service requirements, including the Medicaid Systems of Care, from Exhibit B – Statement of Work do not change.

1.1.1. This Exhibit M operates under the state authority for §25.5-5-415, C.R.S and is a limited managed care capitation initiative within the ACC program based on responses to the Department's RFP UHAA 2024-0332.

1.1.2. Contractor shall manage the limited managed care capitation initiative such that the capitation rates may be set at two percent or more below the fee-for-service equivalent. The savings target of two percent may be adjusted based on mutual agreement by the Department and Contractor upon completion of an actuarial and data review process. The actuarial and data review process shall be completed in advance of the annual rates setting process for rates effective on July 1, 2025, and every year thereafter. The Department and Contractor may agree to set an alternate target, as appropriate to reflect policy objectives regarding the total cost of care and value-based payment, upon completion of the actuarial review process. In no case shall the target be set at a level greater than 100% of the fee-for-service equivalent, pursuant to budget neutrality requirements set forth in the Colorado statutes.

1.2. Contractor shall provide physical health managed care services for Members who meet the eligibility requirements necessary to be enrolled in the MCO and reside in Delta, Garfield, Gunnison, Mesa, Montrose, Ouray, Pitkin, Rio Blanco, and San Miguel counties (referred to as service area).

1.2.1. Contractor shall administer this MCO 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.

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

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

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

1.4. Contractor shall conduct the Work in manner that achieves the ACC mission of improving Member health and reducing costs in the Medicaid Program.

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

1.5. Contractor shall perform all requirements in compliance with all pertinent state and federal statutes, regulations and rules, including the Department's 1915(b) waiver for the ACC and any other 1115 waivers designated by the Department, including, at minimum all of the following:

1.5.1. Title IV of the Civil Rights Act (CRA) of 1964.

1.5.2. The Age Discrimination Act of 1975.

1.5.3. The Rehabilitation Act of 1973.

1.5.4. Title IX of the Education Amendments of 1972.

1.5.5. The Americans with Disabilities Act.

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

1.6. Contractor shall have a governing body responsible for oversight of Contractor's activities in relation to Exhibit M.

1.6.1. Contractor shall at a minimum, perform all of the following:

1.6.1.1. Select representatives of the Community to join the governing body and is required to have a Member representative.

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

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

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

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

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

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

1.6.2.1. Contractor shall include as conflicts of interests, any party that has, or may have, the ability to control or significantly influence Contractor, or a party that is or may be controlled or significantly influenced by a Contractor, including, at a minimum, all of the following:

1.6.2.1.1. Agents.

1.6.2.1.2. Managing employees.

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

1.6.2.1.4. Members of the governing body or governing board.

1.6.2.1.5. Subcontractors.

1.6.2.1.6. Wholly owned subsidiaries or suppliers.

1.6.2.1.7. Parent companies.

1.6.2.1.8. Sister companies.

1.6.2.1.9. Holding companies.

1.6.2.1.10. Other entities controlled or managed by any such entity or persons.

1.6.3. Contractor shall post the approved MCO Governance Plan publicly on Contractor's website.

1.6.4. Contractor shall deliver the MCO Governance Plan to the Department on an annual basis for approval.

1.6.4.1. **DELIVERABLE:** Annual MCO Governance Plan

1.6.4.2. **DUE:** 30 days prior to the Operational Start Date, then annually starting June 1, 2026

1.6.5. Contractor shall submit an updated MCO Governance Plan to the Department and post it publicly on Contractor's website when a change is made to the Governance Plan, or a change in governance is discovered by Contractor.

1.6.5.1. **DELIVERABLE:** Updated MCO Governance Plan

1.6.5.2. **DUE:** No more than 30 days after the new change in governance is made or discovered

1.7. Personnel

1.7.1. Contractor shall possess the organizational resources and commitment necessary to perform the work and successfully implement and operate the ACC program in Contractors' service area. Specifically, Contractor shall:

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

1.7.1.2. Have a physical office located in the service area, unless otherwise approved by the Department in writing.

1.7.1.3. Contractor shall take into consideration the diversity of the community and the Members it serves when hiring Key Personnel and Other Personnel.

1.7.1.4. Contractor shall provide qualified Key Personnel and Other Personnel as necessary to perform the Work throughout the term of the Contract.

1.7.2. Contractor shall provide the Department with a final list of management and supervisory staff assigned to the Contract – Exhibit M and appropriate contact information for those individuals.

1.7.2.1. **DELIVERABLE:** Management/Supervisory Staff Contact Information

1.7.2.2. **DUE:** Within five Business Days following the Effective Date

1.7.3. Contractor shall update this list upon the Department's request to account for changes in the individuals assigned to the Contract and deliver to the Department for review and approval.

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

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

1.7.4. 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.

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

1.7.5.1. **DELIVERABLE:** Organizational Chart

1.7.5.2. **DUE:** Five Business Days after the Effective Date

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

1.7.6.1. **DELIVERABLE:** Updated Organizational Chart

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

1.7.7. Contractor shall not change individuals in Key Personnel or Other 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 Department provided, Key Personnel Approval Form for Contractor's candidate for the position, along with the candidate's resume and copies of required professional license(s)/certification(s). The Department shall provide feedback on the candidate within five Business Days of Contractor's submission of the required information.

1.7.7.1. **DELIVERABLE:** Key Personnel Approval Form

1.7.7.2. **DUE:** Within five Business Days following Contractor's identification of a potential replacement.

1.7.8. 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.

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

1.7.10. Personnel Availability

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

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

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

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

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

1.7.10.5. All of Contractor's Key Personnel and Other Personnel that attend any meeting with the Department or other Department stakeholders that is scheduled to be in person 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. Contractor shall respond to all telephone calls, voicemails and emails from the Department within one Business Day of receipt by Contractor.

1.8. Key Personnel

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

1.8.2. Contractor shall have the following Key Personnel positions dedicated to this Statement Of Work. Individuals filling Key Personnel positions shall be distinct from the individuals filling Key Personnel positions under the Exhibit E, of Exhibit B.

1.8.2.1. Program Officer – One full-time employee.

1.8.2.1.1. The Program Officer shall:

1.8.2.1.1.1. Have senior management decision-making authority regarding this Exhibit M.

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

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

1.8.2.1.1.4. Ensure the completion of all Work in accordance with Exhibit M, requirements, including, at a minimum, ensuring the accuracy, timeliness, and completeness of all Work.

1.8.2.1.1.5. Participate in Department-led meetings to discuss the progress and direction of Exhibit M.

1.8.2.1.1.6. The Program Officer shall have the following qualifications:

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

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

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

1.8.2.2. Contract Manager – One full time employee.

1.8.2.2.1. The Contract Manager shall:

1.8.2.2.1.1. Serve as Contractor's primary point of contact for Exhibit M and for all Work performance.

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

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

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

1.8.2.2.1.5. Work out of an office within Contractor's Service Area.

1.8.2.3. Utilization Management Manager – One full time employee.

1.8.2.3.1. The Utilization Management Manager shall:

1.8.2.3.1.1. Lead and develop the Utilization Management program for Exhibit M and manage the medical review and authorization process.

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

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

1.8.2.3.2. The Utilization Management Manager shall have the following qualifications:

1.8.2.3.2.1. Registered Nurse or higher level of clinical certification.

1.8.2.3.2.2. Minimum of three years' cumulative experience in Utilization Management and managed care.

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

1.8.2.4. Other Personnel Responsibilities

1.8.2.4.1. Contractor shall use its discretion to determine the number of Other Personnel necessary to perform the Work in accordance with the requirements of Exhibit M.

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

1.8.2.4.3. 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 Department-provided training specifically described in Exhibit M.

1.8.2.5. Subcontractors

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

1.8.2.5.2. Contractor shall not subcontract more than 40% of the total value of Exhibit M; this does not apply to the division of responsibilities between joint owners of Contractor.

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

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

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

1.8.2.5.4.2. **DUE:** July 1, 2025

1.8.2.5.5. Contractor shall ensure that all subcontracts are executed in accordance with 42 CFR § 438.230.

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

1.8.2.5.6.1. **DELIVERABLE:** Notice of Subcontractor Termination

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

2. MEMBER ENROLLMENT AND ATTRIBUTION

2.1. Contractor shall review and comply with the Member enrollment, attribution, and assignment processes outlined in this section.

2.1.1. Individuals in the following Program Aid Codes are eligible for enrollment in Contractor's MCO:

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

2.1.1.1.1. HCBS CCT (Colorado Choice Transition) - M7.

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

2.1.1.1.3. HCBS DD (Developmentally Disabled) – M6.

2.1.1.1.4. HCBS SLS (Supported Living Services) – MC.

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

2.1.1.1.6. HCBS BI (Brain Injury) - M1.

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

2.1.1.1.8. HCBS CLLI (Children with Life Limiting Illness) – MD.

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

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

2.1.1.1.11. HCBS CWA (Children with Autism) - M9.

2.1.1.1.12. HCBS SCI (Spinal Cord Injury) - M5.

2.1.1.2. NF/Hospital 300% Institutionalized – MJ.

2.1.1.3. SSI Mandatory – BJ.

2.1.1.4. Former Foster Care – FF.

2.1.1.5. Pickle - B1.

2.1.1.6. DAC (Disabled Adult Child) – BF.

2.1.1.7. QDW (Qualified Disabled Widow/er) – BM.

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

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

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

2.1.1.11. MAGI Pregnant (Modified Adjusted Gross Income, pregnant clients) – HP.

2.1.1.12. Legal Immigrant Prenatal – HB.

2.1.1.13. Psych <21 - H1.

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

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

2.1.1.16. Transitional Med - H3.

2.1.1.17. 4 Month Extended – H6.

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

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

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

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

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

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

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

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

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

2.3. The Department will enroll Members into Contractor's MCO 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:

2.3.1. Enrollment During Hospitalization

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

2.3.1.1.1. Contractor shall, within 14 days of the date Contractor discovers the Member or Potential Member's hospital admission, request in writing to the Department that the enrollment be delayed. Contractor's request shall include the name of the hospital where the Member or Potential Member was inpatient and the date of admission. The Department shall respond to Contractor in writing within five Business Days of Contractor's request to postpone enrollment or upon confirmation of the hospitalization, whichever is later.

2.4. If a Member loses Medicaid eligibility for two months or less, the Department will automatically re-enroll the Member with the MCO that was in effect at the time of the Member's loss of Medicaid eligibility.

2.4.1. Contractor shall monitor re-enrollment notices and ensure a seamless continuation of services for re-enrolled Members.

2.5. Contractor shall:

2.5.1. Accept all Members assigned by the Department in the order assigned and without restriction.

2.5.1.1. The Department will enroll Members with the appropriate aid eligibility category and in Contractor's service area until the enrollment cap, as defined in Section 2.12, has been met.

2.5.2. Implement and maintain policies that support the State's "Colorado for All" initiative by prohibiting discriminating against Members based on race, color, ethnicity, national origin, ancestry, age, sex, gender, sexual orientation, gender identity or expression, religion, creed, political beliefs or disability.

2.5.3. Ensure Members are not discriminated against in enrollment, re-enrollment, or access to services based on health status or need for health care services.

2.6. All Members enrolled in Contractor's limited managed care capitation initiative will have 90 days in which to opt out. Those who do not opt out shall be enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice. Subsequent enrollment shall be for 12 months, and a Member may not disenroll from Contractor's limited managed care capitation initiative except as provided in Section 2.12.2, disenrollment from the limited managed care capitation initiative.

2.7. 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 using person-first, plain language best practices, and must be shared with Department's designated Exhibit M manager for approval.

2.8. 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.

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

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

2.11. Caseload and Enrollment Cap Growth

2.11.1. 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 Contractor's enrollment cap. The annual budget forecasts and caseload trends are selected based on statistical modeling and trend analysis.

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

2.11.1.2. Contractor's enrollment cap is set at 60,000 members for SFY 2025-2026.

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

2.12. Disenrollment from the limited managed care capitation initiative:

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

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

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

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

2.12.1.4. Member moves out of Contractor's service area.

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

2.12.1.6. 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.

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

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

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

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

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

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

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

2.12.2. Disenrollment for cause shall not include disenrollment of, at minimum, any of the following:

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

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

2.12.2.3. The Member's diminished mental capacity.

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

2.12.3. The Department may disenroll any Member who requests disenrollment, in its sole discretion.

2.12.4. The Department may disenroll a Member from Contractor's limited managed care capitation initiative upon that Member's request. A Member (or Member representative) may request

disenrollment to the Department, either written or orally, and the Department may grant the Member's request:

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

2.12.4.1.1. Member moves out of Contractor's service area.

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

2.12.4.1.3. 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 Member to unnecessary risk.

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

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

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

2.12.4.1.7. Lack of access to Providers experienced in dealing with Member's health care needs.

2.12.4.1.8. Member Enrolled in Contractor's limited managed care capitation initiative with the Member's Physician and the Physician leave Contractor.

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

2.12.4.1.10. Member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than the limited managed care capitation imitative offered by Contractor and Contractor cannot provide the Member with reasonable access to a Medicare approved Provider or, if the Member is enrolled in a Medicare managed care plan, Contractor cannot provide the Member with Providers participating in both plans.

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

2.12.4.1.12. 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.

2.12.4.2. Without cause, under the following circumstances:

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

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

2.12.4.2.3. 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.

2.12.4.2.4. A Member may request disenrollment if the Department imposes the intermediate sanction specified in 42 CFR § 438.702(a)(3).

2.12.4.3. 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 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.

2.12.4.4. In the event that a Member is disenrolled from 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 Member became ineligible.

2.12.4.5. 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.

2.12.5. Contractor shall use reports and information from interChange to verify the Medicaid eligibility and enrollment in Contractor's limited managed care capitation initiative for its Members. These reports may include some or all of the following:

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

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

2.12.6. Effective Date of Disenrollment

2.12.6.1. 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.

2.12.6.2. 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.

2.12.6.3. Disenrollment Postponed Due to Inpatient Hospital Stay

2.12.6.3.1. 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 Member disenrollment from Contractor's plan is scheduled to take effect, disenrollment shall be postponed until the last day of the month in which the Member is discharged from the Hospital.

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

3. MEMBER ENGAGEMENT

3.1. Contractor shall prioritize Member engagement by incorporating Member feedback and input into the development, implementation and continuous improvement of all aspects of Contractor's Work.

3.2. Person-and Family-Centered Approach

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

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

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

3.2.1.3. Proactive education that promotes the effective utilization of Medicaid benefits and the health care system.

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

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

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

3.3. Cultural Responsiveness

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

3.3.2. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non- English languages in Contractor's service area. Contractor shall create written materials in English and Spanish or any other prevalent language, as directed by the Department or as required by 42 CFR § 438.10.

3.3.3. Contractor shall provide cultural and disability competency training to Contractor staff and make trainings available to Network Providers regarding:

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

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

3.3.3.3. **PERFORMANCE STANDARD:** 90% of all Contractor staff shall have completed training in cultural and disability competence annually.

3.3.3.4. **PERFORMANCE STANDARD:** Contractor shall ensure that 90% of Network Providers offer cultural and disability competency training for staff annually or that Network Providers and their staff have the opportunity to participate in Contractor-offered cultural and disability competency training on an annual basis.

3.3.4. Contractor shall utilize staff, tools, and resources to support Members whose cultural identity, norms, and practices may affect their access to3. health care.

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

3.3.5.1. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, remaining in compliance with Accessibility requirements as described in Section 16.U of this Contract.

3.3.6. Contractor shall provide language assistance services as required by 42 CFR § 438.10, for all Contractor interactions with Members and for all Covered Services and Medicaid covered services delivered by Network Providers. Language assistance services shall include bilingual staff and interpreter services, at no cost to any Member. These services shall be provided at all points of contact, in a timely manner and during all hours of operation. Contractor shall implement technologies for language assistance services in accordance with standards specified by the Department or as otherwise required by applicable law or regulation.

3.3.6.1. Contractor shall make oral interpretation available in all languages and written translation available in each prevalent non-English language, based on U.S. Census Bureau data, available at no cost to any Member.

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

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

3.3.6.2. Contractor shall notify Members verbally and through written notices regarding the Member's right to receive the following language assistance services at no cost, as well as how to access, at minimum, the following language assistance services:

3.3.6.2.1. Oral interpretation for any language. Oral interpretation requirements apply to all non-English languages, not just those that are identified as prevalent.

3.3.6.2.2. Written translation in prevalent languages.

3.3.6.2.3. Auxiliary aids and services for Members with disabilities.

3.3.6.3. Contractor shall ensure that language assistance services include the use of auxiliary aids such as Teletypewriters/Telecommunication Device for the Deaf (TTY/TDD) and American Sign Language (ASL).

3.3.6.4. Contractor shall ensure that all Contractor customer service call centers, as per outlined requirements in section 3.3, can easily access interpreter or bilingual services.

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

3.3.6.6. Contractor shall report on the provision of language assistance services to Members in the Health Equity Plan as required in Section 6.3.8, in a format approved by Contractor and Department, as requested by the Department.

3.3.7. Written Materials for Members

3.3.7.1. Contractor shall ensure that all written materials it creates for distribution to Members meet all noticing requirements of 45 CFR Part 92.

3.3.7.2. Contractor shall ensure that Member communications adhere to the Department's brand standards.

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

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

3.3.7.4. 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 Contractor's region.

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

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

3.3.7.6. Contractor shall write all materials in easy-to-understand language and format and comply with all applicable requirements of 42 CFR § 438.10.

3.3.7.6.1. Contractor shall comply with all applicable requirements of § 25.5-4-212,C.R.S. including using person-first, plain language best practices. Plain language best practices shall include, but are not limited to, guidelines available at www.plainlanguage.gov.

3.3.7.6.1.1. Contractor shall participate in established plain language trainings provided by the Department.

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

3.3.7.7. Contractor shall translate all written information into other non-English languages prevalent in Contractor's service area.

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

3.3.7.9. 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/TDD telephone number of Contractor's Member service unit, at no cost.

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

3.3.7.11. In accordance with § 25.5-4-212, C.R.S., Contractor shall define "[Member] correspondence" as any communication, the purpose of which is to provide notice of an approval, denial, termination, or change to an individual's Medicaid eligibility; to provide notice of the approval, denial, reduction, suspension, or termination of a Medicaid benefit; or to request additional information that is relevant to determining an individual's Medicaid eligibility or benefits.

3.3.7.11.1. Contractor shall submit all templates of Member correspondence subject to § 25.5-4-212, C.R.S. to the Department for review before distribution. Contractor shall make changes to templates as requested by the Department.

3.3.7.11.2. Member correspondence templates shall be defined as a sample notice that does not include any personal identifiable information.

3.3.7.11.2.1. **DELIVERABLE:** Member correspondence templates

3.3.7.11.2.2. **DUE:** Within 10 Business Days of creation of a new Member correspondence template or an update to an existing template, and prior to distribution to any Members.

3.3.7.12. When requested, Contractor shall use Member notices developed by the Department.

3.3.7.13. Contractor shall provide to the Department any documentation developed by Contractor for the purposes of Member correspondence within three Business Days after the Department's request.

3.4. Member Communications

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

3.4.2. Contractor shall maintain, staff, and publish the number for a single toll-free telephone line that Members may call for assistance. Member assistance shall include, but is not limited to, accessing Colorado Medicaid benefits, finding providers, understanding Colorado Medicaid benefits, customer service, requests for Care Coordination support, and filing grievances and appeals.

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

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

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

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

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

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

3.4.3. Contractor may provide additional methods, such as web-based forms, for Members to request assistance from Contractor.

3.4.3.1. Contractor shall collaborate with the Department to establish and define inquiry types that categorize the common questions or reasons Members request assistance.

3.4.3.1.1. Contractor shall record an inquiry type for each inquiry received by Contractor.

3.4.3.1.2. Contractor shall respond to all Member inquiries within two Business Days.

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

3.4.3.2.1. Contractor's Member assistance surveys shall measure, at a minimum, all of the following areas:

3.4.3.2.1.1. Overall satisfaction with the services provided by Contractor.

3.4.3.2.1.2. Member's satisfaction with how Contractor explained the assistance options available to the Member.

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

3.4.3.3. Contractor shall document and implement a clear process for how Contractor shall escalate a Member request for assistance when the Member requests and when a Contractor staff determines further support is required to address a Member's needs.

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

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

3.4.3.4.2. Voicemails and other asynchronous methods that Members utilize to submit requests for assistance not returned within one business day, in both number and percentage of all requests received

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

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

3.4.3.4.5. Overall totals for request types and subtypes.

3.4.3.4.5.1. **DELIVERABLE:** Member Assistance Statistics Report

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

3.4.3.4.6. **PERFORMANCE STANDARD:** 98% compliance with each Member call line contact management requirement each month.

3.4.4. Contractor shall maintain sufficient licenses to connect to the Department's Member Contact Center's (MCC) Customer Relationship Management (CRM) system to easily and quickly transfer Members between Contractor and the MCC, enable Contractor to access the Department's Knowledgebase when responding to Member questions and collaborate on large-scale Member communication scheduling with the Department.

3.4.4.1. The Department will provide to Contractor a number of licenses for the Department's CRM agreed upon by Contractor and the Department.

3.4.4.2. Contractor may use the Department's CRM as its primary CRM tool at its discretion; if Contractor does not use the Department's CRM as its primary tool, Contractor shall maintain its own CRM system to meet the requirements of this Contract.

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

3.4.6. General Member Information Requirements

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

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

3.4.6.1.2. Contractor's email address.

3.4.6.1.3. Contractor's website address.

3.4.6.1.4. State relay information.

3.4.6.1.5. The basic features of the RAE's managed care functions as a PCCM Entity and MCO.

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

3.4.6.1.7. The service area covered by Contractor.

3.4.6.1.8. Medicaid benefits, including:

3.4.6.1.8.1. State Plan benefits provided by the Department

3.4.6.1.8.2. Limited managed care capitation initiatives provided by Contractor.

3.4.6.1.8.3. Information about where and how to obtain counseling and referral services that Contractor does not cover because of moral or religious objections, in compliance with 42 CFR § 438.10(e)(2)(v)(C).

3.4.6.1.9. Any restrictions on the Member's freedom of choice among Network Providers. 3.4.5.1.10.

3.4.6.1.10. A directory of Network Providers.

3.4.6.1.11. The requirement for Contractor to provide adequate access to physical health services included in the Capitated Physical Health Benefit, including the network adequacy standards defined in Section 5.

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

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

3.4.6.2. Contractor shall notify Members when Contractor adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 calendar days prior to the effective date of the policy for any particular service, in compliance with 42 CFR § 438.10(g).

3.4.7. Member Rights

3.4.7.1. Contractor shall have written policies guaranteeing each Member's right to be treated with respect and due consideration for the Member's dignity and privacy.

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

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

3.4.7.2.2. 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.

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

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

3.4.7.2.5. The right to request and receive a copy of the Member's medical records and request that they be amended or corrected.

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

3.4.7.2.7. Freely exercise the Member's Rights with Contractor or its Providers treating the Member adversely.

3.4.7.3. Contractor shall post and distribute Member Rights to individuals, including but not limited to:

3.4.7.3.1. Members.

3.4.7.3.2. Member's families, guardians, or caregivers.

3.4.7.3.3. Providers.

3.4.7.3.4. Case workers.

3.4.7.3.5. Stakeholders.

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

3.4.8. Member Handbook

3.4.8.1. Contractor shall work jointly with the Department on a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 CFR § 438.10. The Member Handbook shall include, at a minimum, all of the following:

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

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

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

3.4.8.1.4. Access to Benefits

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

3.4.8.1.4.2. Extent to which, and how, Members may obtain benefits, including family planning services and supplies from Out-of-Network Providers.

3.4.8.1.5. Emergency and After Hours Care

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

3.4.8.1.5.1.1. 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 Member, the health of the Member or their unborn child) in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

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

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

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

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

3.4.8.1.5.1.6. The locations of any emergency settings and other locations at which Providers and hospitals furnish emergency services and Post-Stabilization Services covered under the Contract.

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

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

3.4.8.1.7. A statement that prior authorization is not required to receive services from family planning Providers.

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

3.4.8.1.9. Member rights and responsibilities.

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

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

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

3.4.8.1.13. A section with information specific to Contractor's service area.

3.4.8.2. Contractor shall submit comprehensive contact information to the Department for inclusion in the Colorado Medicaid Member Handbook to the Department. This information shall include, at a minimum:

3.4.8.2.1. Contractor's primary contact phone number(s), email address(es), and physical address(es) for Member inquiries.

3.4.8.2.2. Hours of operation during which Members can access assistance.

3.4.8.2.3. Any other designated contact method and supporting information necessary for resolving Member concerns, as necessary.

3.4.8.2.3.1. **DELIVERABLE:** Colorado Medicaid Member Handbook Contractor contact information.

3.4.8.2.3.2. **DUE:** Five Business days after the Effective Date.

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

3.4.8.2.4.1. **DELIVERABLE:** Updated Colorado Medicaid Member Handbook Contractor Contact Information.

3.4.8.2.4.2. **DUE:** 30 days prior to any of Contractor's contact information changes taking effect.

3.4.9. Contractor Website

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

3.4.9.1.1. Contractor's contact information.

3.4.9.1.2. Member rights and handbooks.

3.4.9.1.3. Grievance and Appeal procedures and rights.

3.4.9.1.4. General functions of Contractor.

3.4.9.1.5. Trainings.

3.4.9.1.6. Access to care standards.

3.4.9.1.7. Health First Colorado Nurse Advice Line.

3.4.9.1.8. Colorado Crisis Services information.

3.4.9.1.9. Non-Emergent Medical Transportation (NEMT) benefit information including links for regional Providers and instructions for obtaining rides and submitting requests for mileage reimbursement.

3.4.9.2. For PCMPs and Behavioral Health Providers, Contractor shall make information on Contractor's Network Providers available to Members as a Network Directory in electronic form and in paper form upon request.

3.4.9.2.1. Contractor shall ensure that the electronic Network Directory is updated no later than five Business Days after Contractor receives updated Provider information.

3.4.9.2.2. Contractor shall update the paper Network Directory at least quarterly as required by 42 CFR § 438.10(h)(3).

3.4.9.2.2.1. Contractor shall include the following information about Network Providers in the Network Directory:

3.4.9.2.2.1.1. Names, as well as any group affiliations.

3.4.9.2.2.1.2. Street addresses.

3.4.9.2.2.1.3. Telephone numbers.

3.4.9.2.2.1.4. Website addresses, as appropriate.

3.4.9.2.2.1.5. Specialties, as appropriate.

3.4.9.2.2.1.6. Whether network Providers will accept new Members.

3.4.9.2.2.1.7. The cultural and linguistic capabilities of Network Providers, including languages including, but not limited to, ASL offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the Provider has completed cultural competence training.

3.4.9.2.2.1.8. Whether Network Providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

3.4.9.2.2.1.9. Whether the Network Provider offers Covered Services via telehealth.

3.4.9.2.3. Contractor shall submit the Network Directory to the Department.

3.4.9.2.3.1. **DELIVERABLE:** Network Directory

3.4.9.2.3.2. **DUE:** Five days prior to the Operational Start Date, and within 30 days after changes to the Network Directory

3.4.9.2.4. Contractor shall update the Network Directory within 30 calendar days after receipt from the Department with corrected Provider information discovered during a Secret Shopper Survey, as required by 42 CFR § 438.10(h)(3).

3.4.9.2.4.1. **PERFORMANCE STANDARD:** Contractor shall achieve a Network Directory accuracy score as agreed upon by the Department and MCEs but no less than 80% on the Department's annual audit of the Network Directory or the annual independent Secret Shopper Survey, with the goal that by SFY 2028-29 the accuracy score is no less than 90%. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

3.4.9.2.5. Contractor shall make the Network 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.

3.4.9.2.6. Contractor shall include in the Network Directory information on each of the following Provider types covered under the contract:

3.4.9.2.6.1. Physicians, including specialists.

3.4.9.2.6.2. Hospitals.

3.4.9.2.6.3. Pharmacies.

3.4.9.2.6.4. Mental health and SUD Providers.

3.4.9.3. Contractor shall offer individualized support to Members in finding a PCMP or Behavioral Health Provider, in addition to providing the Network Directory.

3.4.9.4. Contractor shall provide a link to the Department's website on Contractor's website for standardized information such as Member Rights and Colorado Medicaid Member Handbook.

3.4.9.5. Contractor shall provide a statement on Contractor's website that all Member information required in this Section 3.4. is available in paper form without charge upon request within 5 Business Days after the Member's request is made.

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

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

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

3.4.10. Termination of Provider Agreements

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

3.4.10.2. Contractor shall provide Members in ongoing Physical Health treatment appropriate supports and Care Coordination to prevent exacerbation of a Member's health condition while Contractor works to connect the Member with a new treatment Provider.

3.4.11. Information on Grievance and Appeals Process

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

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

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

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

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

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

3.4.11.1.6. The method for obtaining a State Fair Hearing.

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

3.4.11.1.8. Statement that benefits will continue, when requested by the Member, if the Member files a timely Appeal or State Fair Hearing request.

3.4.11.1.9. Any Appeal rights the State makes available to Providers to challenge the failure of Contractor to cover a service.

3.4.12. Advance Directives

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

3.4.12.2. At the time of initial enrollment, Contractor shall provide written information to adult Members with respect to advance directives policies which shall include all of the following:

3.4.12.2.1. A description of applicable State law.

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

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

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

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

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

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

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

3.4.13. Other Member Information

3.4.13.1. Contractor shall provide other necessary information to Members and their families, as determined by the Department. This information shall include, but not be limited to the services provided by EPSDT and how to obtain additional information.

3.4.14. Member Material Review Process

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

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

3.4.14.2.1. **DELIVERABLE:** Notification of large-scale Member communication initiative.

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

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

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

3.4.15. Electronic Distribution of Federally Required Information

3.4.15.1. In order to electronically distribute information required by 42 CFR § 438.10 to Members, Contractor shall meet all of the following conditions:

3.4.15.1.1. The format is readily accessible and complies with modern accessibility standards such as ADA, Sections 504 and 508 of the Rehabilitation Act, and in compliance with the accessibility requirements outlined in Section 16.U of this Contract.

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

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

3.4.15.1.4. The information is consistent with the content and language requirements of 42 CFR § 438.10.

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

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

3.4.15.2.1. Contractor shall help Members with the process for submitting the Member's updated contact information, renewals and verifications via PEAK at CO.gov/PEAK or in the Health First Colorado mobile application (free and available from Apple and Google Play) upon the Member's request, depending on Member access to these options.

3.4.15.2.1.1. Contractor shall not:

3.4.15.2.1.1.1. Act on the Member's behalf or in place of registered assisters

3.4.15.2.1.1.2. Complete and/or sign a Medicaid application or renewal on a Member's behalf, even in the presence of or on the phone with a Member.

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

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

3.4.15.4.1. In the course of providing renewal assistance, Contractor shall not:

3.4.15.4.1.1. Act on the Member's behalf or in place of registered assisters;

3.4.15.4.1.2. complete and/or sign a Medicaid application or renewal on a Member's behalf, even in the presence of or on the phone with a Member; or

3.4.15.4.1.3. Influence a Member who will lose or may lose Medicaid eligibility to enroll in a qualified health plan offered by Contractor or an entity that is connected to Contractor.

3.5. EPSDT Outreach

3.5.1. Contractor shall inform pregnant Members and EPSDT eligible Members, or their families, guardians, or caregivers, about the comprehensive EPSDT program that includes physical, behavioral, oral, and vision health benefits, in accordance with requirements specified in 42 CFR § 441.56 and the State Medicaid Manual Chapter V, Section 5121.

3.5.1.1. Contractor shall inform Members about the EPSDT program generally within 60 days after the Member's initial Medicaid eligibility determination or after a Member regains eligibility following a greater than 12-month period of ineligibility.

3.5.1.2. Contractor shall inform Members about the EPSDT program generally within 60 days after identification of the Member being pregnant.

3.5.1.3. At least one time annually, Contractor shall outreach Members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care."

3.5.1.4. Contractor shall provide to households with EPSDT-eligible Members, including children involved with Child Welfare, at minimum, all of the following information:

3.5.1.4.1. The benefits of preventive health care, including the American Association of Pediatrics' "Bright Futures Guidelines."

3.5.1.4.2. The services available to Members under the EPSDT program.

3.5.1.4.3. Where EPSDT services are available and appointment assistance if requested by Members.

3.5.1.4.4. How to obtain EPSDT services, including those not offered under this Contract.

3.5.1.4.5. How Contractor can provide necessary assistance with scheduling appointments for services.

3.5.1.4.6. EPSDT services are available without cost to the Member.

3.5.1.4.7. How to request necessary transportation, reimbursement for mileage, and transportation scheduling assistance from Contractor or other vendor.

3.5.1.5. Contractor shall be accountable for providing information on EPSDT at least once to households with multiple EPSDT-eligible Members residing in the household. Contractor will not be held accountable for providing EPSDT information to each individual EPSDT-Eligible Member residing in the household.

3.5.1.6. Contractor does not need to inform households more than once in a 12-month period when Members lose and regain Medicaid eligibility during that 12-month period.

3.5.1.7. Contractor's communications about EPSDT shall be delivered using easy-to-understand, plain language best practices.

3.5.1.8. Contractor shall use a combination of oral and written materials to outreach EPSDT-eligible Members, as permitted under the Telephone Consumer Protection Act, including but not limited to:

3.5.1.8.1. Mailed brochures or pamphlets.

3.5.1.8.2. Face-to-face interactions.

3.5.1.8.3. Telephone calls.

3.5.1.8.4. Video conferencing.

3.5.1.8.5. Automated calls.

3.5.1.8.6. Email messages.

3.5.1.8.7. Text/SMS messaging.

3.5.1.9. 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 Academy of Pediatrics' (AAP) "Bright Futures Guidelines."

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

3.5.1.11. Contractor shall employ proven best practices for outreach including:

3.5.1.11.1. Using multiple methods of communication.

3.5.1.11.2. Staggering message delivery to different days of the week or hours of the day.

3.5.1.11.3. Limit telephone (including automated) calls and text messages to between the hours of 8:00 AM MST and 9:00 PM MST. Monday through Friday and 10:00 AM MST through 4:00 PM MST Saturday or Sunday.

3.5.1.11.4. Attempt to reach Members more than once through multiple methods as outlined in Section 3.5.1.8.

3.5.1.11.5. Target outreach activities to particular "at risk" groups, to be defined by Contractor and with final approval by the Department.

3.5.1.12. 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:

3.5.1.12.1. Head Start.

3.5.1.12.2. Early Intervention under the Individuals with Disabilities Education Act (IDEA).

3.5.1.12.3. WIC.

3.5.1.12.4. School health programs of state and local education agencies.

3.5.1.12.5. Social services programs under Title XX.

3.5.1.13. Contractor shall collaborate with the Department on best practices for educating Members about EPSDT and for outreaching EPSDT-Eligible Members to improve adherence to the AAP "Bright Futures Guidelines."

3.5.1.14. 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.

3.5.1.15. Contractor shall submit to the Department an annual EPSDT Outreach Plan that describes processes utilized to effectively inform Members as required, generally, within 60 days after the Member's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

3.5.1.15.1. **DELIVERABLE:** EPSDT Outreach Plan

3.5.1.15.2. **DUE:** Annually, on July 31

3.5.1.16. 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 shall include descriptions of Contractor's communication methods for outreach and individual Member reporting of completed outreach activities and attempted outreach activities.

3.5.1.16.1. **DELIVERABLE:** EPSDT Outreach Report

3.5.1.16.2. **DUE:** Quarterly, 45 days after the end of the quarter the report covers

3.5.1.16.3. **PERFORMANCE STANDARD**: 95% of children and youth newly determined eligible for Medicaid have been outreached about EPSDT within 60 days after the Member's Medicaid eligibility determination.

3.5.1.16.4. **PERFORMANCE STANDARD:** 95% of children and youth who have not utilized EPSDT services in the previous 12 months have been outreached about engagement in preventive care in accordance with "AAP Bright Futures" guidelines.

3.6. Marketing

3.6.1. Contractor shall not engage in any Marketing Activities, as defined in 42 CFR § 438.104, during the Start-Up Period.

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

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

3.6.4. 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.

3.6.5. Contractor shall distribute the Marketing Materials to its entire service area.

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

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

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

3.6.9. Contractor shall ensure that Marketing Materials do not contain any assertion or statement, whether written or oral, that Contractor is endorsed by CMS, the federal or state government or similar entity.

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

3.7. Health Needs Survey

3.7.1. The Department has developed a Health Needs Survey to be completed by Members as part of the eligibility and onboarding process to identify immediate Member health needs.

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

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

3.7.3.1. Contractor shall review the Member responses to the Health Needs Survey each Business Day to identify Members who require timely contact and support from the Member's PCMP or MCO.

3.7.3.2. Contractor shall ensure Members who have completed the Health Needs Survey have been outreached as expeditiously as the Member's reported need requires.

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

3.8. Promotion of Member Health and Wellness

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

3.8.2. Contractor shall develop, implement and promote evidenced-based wellness and prevention programs for Contractor's Members. Contractor shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by the Department including, but not limited to, case management programs for pregnancy and postpartum, diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), pediatric wellness and overall health promotion programs, which include tobacco cessation and behavioral health screenings and follow-up care. Contractor shall also participate in other Colorado public health initiatives at the direction of the Department.

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

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

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

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

3.9. Member Incentives

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

3.9.2. Contractor shall have systems capable of implementing a Member Incentive Program developed by the Department.

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

3.9.3.1. The Department will share the ACC or Value-Based Payment goals with Contractor.

3.9.4. For the Member Incentive Program, Contractor shall provide to participating Members incentives that may include cash, gift cards for specific retailers, vouchers for a farmers market, contributions to health savings accounts that may be used for health-related purchases, gym Memberships or other incentives as approved by the Department and permitted under federal guidance.

3.9.4.1. Incentives shall not, in a given fiscal year for any one Member, exceed a total monetary value as established by the Department.

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

3.9.6. Contractor shall partner with the Department to develop and implement at least one Member Incentive Program designed to address one of the Department's priority areas, which may include, but is not limited to:

3.9.6.1. Increase the timeliness of prenatal care.

3.9.6.2. Childhood immunizations.

3.9.6.3. Address obesity.

3.9.6.4. Prevent diabetes.

3.9.6.5. Support smoking cessation.

3.9.6.6. Contingency Management for SUD.

3.9.7. Contractor shall educate Members who are interested in participating in a Member Incentive Program or who want to receive another form of compensation from Contractor on the potential implications for the Member's Medicaid eligibility and taxes in accordance with Department guidance.

3.9.8. Contractor shall report to the Department, at minimum, annually, the results of Member Incentive Program in the prior 12 months, including, at minimum, all of the following metrics:

3.9.8.1. The incentive(s) offered.

3.9.8.2. The number of Members in the Member Incentive Program's target population, as determined by Contractor.

3.9.8.3. The number of Members who received any incentive payment, and the number who received the maximum amount as a result of participation in the Member Incentive Program.

3.9.8.4. The total value of the incentive payments.

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

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

3.9.8.6.1. **DELIVERABLE:** Member Incentive Program Report

3.9.8.6.2. **DUE:** Annually as determined by the Department

4. GRIEVANCES AND APPEALS

4.1. Overview

4.1.1. In accordance with 42 CFR § 438 Subpart F and 10 CCR 2505-10, Section 8.209 of the Medicaid state rules for Managed Care Grievances and Appeals Processes, Contractor shall have a Grievance and Appeal system, as well as processes to collect and track information about Grievances and Appeals.

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

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

4.1.4. In compliance with §§ 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi), Contractor shall inform Network Providers and subcontractors, at the time Network Providers and Subcontractors enter into a contract with Contractor, about the following:

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

4.1.4.1.1. The requirements and timeframes for filing.

4.1.4.1.2. The availability of assistance with filing.

4.1.4.1.3. The toll-free number to file orally.

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

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

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

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

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

4.2. Quality of Care Grievances

4.2.1. Contractor shall establish and maintain a Quality of Care Grievance (QOCG) process through which Members may express dissatisfaction about any matter related to this Contract other than an Adverse Benefit Determination. Expressions of dissatisfaction may include, at minimum, any of the following:

4.2.1.1. Concern about having been misdiagnosed.

4.2.1.2. Concern about not receiving appropriate treatment.

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

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

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

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

4.2.3.1. Contractor shall document in Contractor's QOCG management system the response and any solutions Contractor has offered to the party that submitted the QOCG.

4.2.4. Contractor shall have processes and procedures to make information about the QOCG process, including how to file a QOCG available to all Members and the QOCG information is provided to all Network Providers and Subcontractors, including Providers under a single case agreement.

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

4.2.5.1. Contractor shall provide a Member with written notice of QOCG receipt within two Business Days of Contractor learning of the QOCG.

4.2.6. Contractor shall not discourage the filing of QOCGs.

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

4.2.7.1. Document the date the incident occurred, as well as the date and time of Contractor's receipt of the QOCG.

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

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

4.2.7.4. Refer QOCGs to Contractor's peer review committee when this venue is available and appropriate. Contractor shall manage peer review deliberations and results as set forth in §§ 12-30-204 and 12-30-205, C.R.S. When a QOCG has been referred to peer review, Contractor shall inform the reporting individual of this in writing, including the provisions of §§ 12-30-204 and 12-30-205, C.R.S., which will limit disclosure of the results.

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

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

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

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

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

4.2.7.9. Resolve the QOCGs and provide written notice to the Member of the resolution, per 42 CFR § 438.408.

4.2.7.9.1. **PERFORMANCE STANDARD**: Contractor shall resolve 90% of QOCGs within 90 calendar days from the date the Member files the QOCG. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

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

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

4.2.7.10.2. Contractor shall provide to the Department sufficient documentation to justify the need for an extension, if requested to by the Department.

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

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

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

4.2.8. QOCG Resolution

4.2.8.1. Contractor shall consider a QOCG as resolved when the following conditions are met:

4.2.8.1.1. The QOCG has reached a conclusion regarding the submitted QOCG; and

4.2.8.1.2. Contractor has provided a letter or email notice, in accordance with the minimum standards of notice defined in C.F.R. 438.10, to the Member with the following information, so long as there is no conflict with §§ 12-30-204 and 12-30-205, C.R.S.:

4.2.8.1.2.1. Conclusion of the investigation.

4.2.8.1.2.2. The date of Contractor's conclusion of the investigation.

4.2.8.2. Contractor shall not consider or report to the Member that a QOCG is resolved when Contractor has only escalated a QOCG within Contractor's organization. Contractor's investigation must be completed fully to be considered as resolved.

4.2.8.3. Contractor shall submit to the Department documentation of a QOCG resolution and any documented recommended solutions upon the Department's request. If the Department determines the solution to be insufficient or otherwise unacceptable, it may direct Contractor to propose a different solution or follow a Department-specified solution.

4.2.8.4. Contractor shall inform a reporting individual who is dissatisfied with the resolution of the QOCG that they may bring the unresolved QOCG to the Department for review and decision making. The Department's decision on a QOCG is final.

4.2.9. Contractor shall notify the Department within two Business Days of Contractor receiving QOCG cases or becoming aware of incidences involving Members that include, but are not limited to, egregious patient safety concerns, Member death, or cases with potential to generate public attention. Contractor shall report these cases using a process and template provided by the Department.

4.2.9.1. **DELIVERABLE:** Immediate Patient Safety Concern Notice

4.2.9.2. **DUE:** Within two Business Days after Contractor is made aware of the Immediate Patient Safety Concern

4.2.10. Contractor must include in its QOCG process specific procedures to rapidly assess and evaluate within 72-hours any QOCGs that involve an imminent and serious threat to the health or safety of the Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function.

4.2.10.1. Contractor's procedures for addressing expedited QOCGs shall include providing notice to the Member within 72 hours in a method that best suits the needs of the Member. Contractor's notice to the Member shall include, but is not limited to:

4.2.10.1.1. Update on status of Contractor's assessment and evaluation of the QOCG.

4.2.10.1.2. Documentation of the date and time the QOCG was received.

4.2.10.1.3. Identification of alternative resources available to the Member based upon the Member's condition and to address the Member's safety.

4.2.10.2. Contractor shall provide a monthly report to the Department on activities related to expedited QOCGs in a Department specified template.

4.2.10.3. Contractor shall exhaust all reasonable efforts to address the imminent and serious threat to the health or safety of the Member within 72 hours of receiving the QOCG.

4.2.10.4. Contractor shall resolve any additional investigation outside of the imminent and serious threat to the health or safety of the Member within the requirements established in this section and in accordance with 42 CFR § 438.408.

4.2.11. Contractor shall document each QOCG, including expedited QOCGs in a QOCG Summary Report to be sent to the Department. This report shall include, at a minimum:

4.2.11.1. Contact information for the reporting individual.

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

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

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

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

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

4.2.11.7. Evidence of the QOCG resolution.

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

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

4.2.12. Contractor shall submit the QOCG Summary Report to Department for review and approval in a format agreed upon by Contractor and the Department.

4.2.12.1.1.1. **DELIVERABLE:** QOCG Summary Report

4.2.12.1.1.2. **DUE:** Monthly, by the 10th Business Day after the end of the reporting month.

4.2.13. If the Department is contacted by a Member, advocates, the Health First Colorado Managed Care Ombudsman, or other individuals/entities with a QOCG regarding concerns about the care or lack of care a Member is receiving, Contractor shall begin processing the QOCG upon notification by the Department using Contractor's QOCG processes and procedures.

4.2.13.1. Contractor shall keep the Department informed about process on resolving concerns and shall advise the Department of final resolution through a process determined by the Department.

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

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

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

4.2.15. The Department may share information about QOCG investigations with Contractor.

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

4.3. Notice of Adverse Benefit Determination

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

4.3.1.1. Is in writing.

4.3.1.2. Complies with Member correspondence requirements of § 25.5-4-212(3), C.R.S:

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

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

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

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

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

4.3.1.2.6. Clearly conveys the purpose of Member correspondence, the action or actions being taken by the Department or its designated entity, if any, and the specific action or actions that Member must or may take in response to the correspondence.

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

4.3.1.2.8. Includes contact information for Member questions.

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

4.3.1.3. Complies with the language and format requirements of 42 CFR § 438.10, including but not limited to:

4.3.1.3.1. Is available in the state-established prevalent non-English languages in its region.

4.3.1.3.2. Is available in alternative formats for persons with special needs.

4.3.1.3.3. Is in an easily understood language and format.

4.3.1.3.4. Includes taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, and information on how to request auxiliary aids and services.

4.3.1.4. Explains the adverse benefit determination Contractor or its subcontractor has taken or intends to take.

4.3.1.5. Explains the reasons for the adverse benefit determination.

4.3.1.6. Identifies alternate services and/or level of care that are recommended instead of the requested service when the original request is denied for lack of medical necessity.

4.3.1.7. Provides information about the Member's right to file an Appeal, or the Provider's right to file an Appeal when the Provider is acting on behalf of the Member as the Member's designated representative.

4.3.1.8. Explains the Member's right to request a State Fair Hearing.

4.3.1.9. Describes how a Member can Appeal.

4.3.1.10. Gives the circumstances under which expedited resolution of an Appeal is available and how to request it.

4.3.1.11. Explains the Member's right to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued.

4.3.1.12. Explains the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination.

4.3.1.13. Explains how each dimension of the most recent edition of American Society of Addiction Medicine (ASAM) criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient SUD services.

4.3.1.14. **PERFORMANCE STANDARD:** 95% of Notices of Adverse Benefit Determinations sent to Members use the template provided by the Department.

4.3.2. Contractor shall have policies and procedures to ensure that decision-makers take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

4.3.3. Contractor shall give notice according to the following schedule:

4.3.3.1. At least ten days before the date of action, if the Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

4.3.3.2. At least five days prior to the date of action, if Contractor has verified information indicating probable beneficiary fraud.

4.3.3.3. By the date of adverse benefit determination when any of the following occur:

4.3.3.3.1. The Member has died.

4.3.3.3.2. The Member submits a signed written statement requesting service termination.

4.3.3.3.3. The Member submits a signed written statement including information that requires termination or reduction and indicates that the Member understands that service termination or reduction will occur.

4.3.3.3.4. The Member has been admitted to an institution in which the Member is ineligible for Medicaid services.

4.3.3.3.5. The Member's address is determined unknown based on returned mail with no forwarding address.

4.3.3.3.6. The Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

4.3.3.3.7. A change in the level of medical care is prescribed by the Member's physician.

4.3.3.3.8. The notice involves an Adverse Benefit Determination with regard to preadmission screening requirements.

4.3.3.3.9. The transfer or discharge from a facility will occur in an expedited fashion.

4.3.3.4. On the date of adverse benefit determination when the adverse benefit determination is a denial of payment.

4.3.3.5. As expeditiously as the Member's health condition requires, but no longer than seven calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

4.3.3.5.1. Contractor may extend the 7 day standard authorization notice timeframe up to 14 additional days if the Member or the Provider requests extension; or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

4.3.3.5.2. If Contractor extends the seven 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 the Member disagrees with the decision.

4.3.3.5.3. If Contractor extends the seven day service authorization notice timeframe, it must issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.3.3.6. On the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

4.3.3.7. For cases in which a Provider, or Contractor, determines that following the standard authorization timeframe could seriously jeopardize the Member's life or health or the Member's ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after Contractor's receipt of the request for service.

4.3.3.7.1. Contractor may extend the 72-hour expedited service authorization decision time period by up to 14 days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

4.3.4. Contractor shall notify the requesting Provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

4.4. Handling Appeals for the Capitated Physical Health Benefit

4.4.1. Contractor shall handle Appeals of adverse benefit determination for the Capitated Physical Health Benefit, in compliance with 42 CFR § 438.400.

4.4.2. Contractor shall acknowledge receipt of each Appeal, in accordance with 42 CFR § 438.406(b)(1).

4.4.3. Contractor shall ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual.

4.4.4. The decision maker shall be a health care professional with clinical expertise in treating the Member's condition or disease if any of the following apply:

4.4.4.1. The Member is appealing a denial that is based on lack of Medical Necessity.

4.4.4.2. The grievance or appeal involves clinical issues.

4.4.5. Contractor shall allow Members, and Providers acting on behalf of a Member and with the Member's written consent, to file Appeals:

4.4.5.1. Within 60 days after the date of Contractor's notice of Adverse Benefit Determination.

4.4.6. Contractor shall have written policies and procedures to ensure that oral inquiries seeking to Appeal an adverse benefit determination are treated as Appeals.

4.4.7. If the Member, or Provider acting on behalf of the Member, orally requests an expedited Appeal, Contractor shall not require a written, signed Appeal following the oral request.

4.4.8. Contractor shall provide a reasonable opportunity for the Member to present evidence and allegations of fact or law, in person, orally, as well as in writing.

4.4.9. If the Member requests an expedited Appeal resolution, Contractor shall inform the Member of the limited time available to present evidence and allegations of fact or law.

4.4.10. Contractor shall give the Member and the Member's representative an opportunity, sufficiently in advance before and during the Appeals process, to examine the Member's case file, including medical records and any other documents and records free of charge and sufficiently in advance of the resolution timeframe.

4.4.11. Contractor shall consider the Member, the Member's representative, or the legal representative of a deceased Member's estate as parties to an Appeal.

4.4.12. Contractor shall take no punitive action against a Provider who either requests an expedited resolution or supports a Member's appeal, in accordance with 42 CFR § 438.410.

4.4.13. Contractor shall have only one level of Appeal for enrollees as required by 42 CFR § 438.402(b).

4.4.14. Continuation of Benefits and Services During an Appeal

4.4.14.1. Contractor shall continue the Member's benefits while a Capitated Physical Health Benefit Appeal is in the process if all of the following are met:

4.4.14.1.1. The Member files the request for an appeal within 60 days after the date of Contractor's notice of adverse benefit determination in accordance with 42 CFR § 438.402(c)(2)(ii).

4.4.14.1.2. A request for a continuation of benefits is filed on or before the later of:

4.4.14.1.2.1. Ten days after Contractor mailed the notice of adverse benefit determination.

4.4.14.1.2.2. The intended effective date of Contractor's proposed adverse benefit determination.

4.4.14.1.3. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

4.4.14.1.4. The services were ordered by an authorized Provider.

4.4.14.1.5. The authorization period has not expired.

4.4.14.2. Contractor shall provide Members with a continuation of benefits during an Appeal or State Fair Hearing through the decision and shall not recoup from Members the cost of any benefits or services that were continued during the appeals process.

4.4.14.2.1. In alignment with 42 CFR 438.420, a continuation of benefits during an Appeal or State Fair Hearing is only available in the case of a termination, suspension, or reduction of previously authorized services. The expiration of previously authorized services shall not be considered a termination, reduction, or suspension, and therefore not eligible for a continuation during the Appeals process.

4.4.14.3. If Contractor continues or reinstates the Member's benefits while the Appeal is pending, the benefits shall be continued until one of the following occurs:

4.4.14.3.1. The Member withdraws the Appeal or request for a State Fair Hearing.

4.4.14.3.2. The Member does not request a State Fair Hearing with continuation of benefits within ten days after the date Contractor mails an adverse Appeal decision.

4.4.14.3.3. A State Fair Hearing decision adverse to the Member is made.

4.4.14.3.4. The service authorization expires, or the authorization limits are met.

4.4.14.4. Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours after the date of reversal if the services were not furnished while the Appeal was pending, and if Contractor or State Fair Hearing Officer reverses a decision to deny, limit, or delay services.

4.4.14.5. Contractor shall pay for disputed services received by the Member while the Appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when Contractor or State Fair Hearing Officer reverses a decision to deny authorization of the services.

4.4.15. Resolution and Notification of Appeals

4.4.15.1. Contractor shall resolve each Appeal and provide notice as expeditiously as the Member's health condition requires and no later than the date the extension expires, and not to exceed the following:

4.4.15.1.1. For standard resolution of an Appeal and notice to the affected parties, ten Business days after the day Contractor receives the Appeal.

4.4.15.1.2. **PERFORMANCE STANDARD:** 95% of Appeals shall be resolved within 10 business days after the day the Appeal was received.

4.4.15.2. Contractor may extend the timeframe for processing an Appeal by up to 14 days if the Member requests or Contractor shows (to the satisfaction of the Department, upon its request) that there is a need for additional information and that the delay is in the Member's best interest.

4.4.15.2.1. Contractor shall provide the Member with written notice within two days after the extension of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member.

4.4.15.3. Contractor shall establish and maintain an expedited review process for Appeals when Contractor determines from a request from the Member or when the Network Provider indicates, in making the request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

4.4.15.3.1. If Contractor denies a request for expedited resolution of an Appeal, Contractor shall transfer the Appeal to the standard timeframe for Appeal resolution and give the Member prompt oral notice of the denial and a written notice within two days after receiving the request for expedited resolution.

4.4.15.3.2. Contractor shall resolve each expedited Appeal and provide notice as expeditiously as the Member's health condition requires, within state- established timeframes not to exceed 72 hours after Contractor receives the expedited Appeal request.

4.4.15.3.3. Contractor may extend the timeframe for processing an expedited Appeal by up to 14 days if the Member requests the extension or Contractor shows that there is need for additional information and that the delay is in the Member's best interest.

4.4.15.3.4. Contractor shall provide the Member with written notice within two days and make a reasonable effort to give the Member prompt oral notice of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member and inform the Member of the right to file a grievance if he or she disagrees with that decision.

4.4.15.3.5. Contractor shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited Appeal.

4.4.15.4. Contractor shall provide written notice of the disposition of the Appeals process, which shall include the results and data of the Appeal resolution.

4.4.15.5. For Appeal decisions not wholly in the Member's favor, Contractor shall include the following:

4.4.15.5.1. The Member's right to request a State Fair Hearing.

4.4.15.5.2. How the Member can request a State Fair Hearing.

4.4.15.5.3. The Member's right to continue to receive benefits pending a hearing.

4.5. State Fair Hearing

4.5.1. Contractor shall allow a Member to request a State Fair Hearing after the Member received notice that Contractor has upheld the adverse benefit determination.

4.5.1.1. The Member has 120 days after the date of Contractor's adverse resolution notice to request a State Fair Hearing.

4.5.2. If Contractor does not adhere to the notice and timing requirements regarding a Member's Appeal, the Member is deemed to have exhausted the Appeal process and may request a State Fair Hearing.

4.5.3. Contractor shall be a party to the State Fair Hearing as well as the Member and the Member's representative or the representative of a deceased Member's estate.

4.5.4. The State's standard timeframe for reaching its decision on a State Fair Hearing request is within 90 days after the date the Member filed the Appeal with Contractor, excluding the days the Member took to subsequently file for a State Fair Hearing.

4.5.4.1. Contractor shall participate in all State Fair Hearings regarding Appeals and other matters arising under this Contract.

4.5.5. Expedited State Fair Hearing

4.5.5.1. When the Appeal is heard first through 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 after the Department's receipt of a hearing request for a denial of service that:

4.5.5.1.1. Meets the criteria for an expedited Appeal process but was not resolved with Contractor's expedited Appeal timeframes, or

4.5.5.1.2. Was resolved wholly or partially adversely to the Member using Contractor's expedited Appeal timeframes.

4.6. Health First Colorado Managed Care Ombudsman

4.6.1. Contractor shall utilize and refer Members to the Health First Colorado Managed Care Ombudsman to assist, at a minimum, with all of the following:

4.6.1.1. Problem-solving.

4.6.1.2. Grievance resolution.

4.6.1.3. In-plan and State Fair Hearing Appeals.

4.6.1.4. Referrals to Community resources, as appropriate.

4.6.2. Contractor shall share Protected Health Information (PHI), with the exception of psychotherapy notes and SUD-related information, with the Ombudsman upon the Ombudsman's request, without requiring a signed release of information or other permission from the Member, unless Contractor has previously obtained written and explicit instructions from the Member not to share information with the Ombudsman.

4.6.2.1. Contractor shall create a policy outlining these requirements that can be easily distributed to Network Providers, subcontractors, advocates, families, and Members.

4.7. Adverse Benefit Determination Reporting

4.7.1. Contractor shall submit an Adverse Benefit Determination Appeals Report to the Department or Department designee in a format and cadence determined by the Department.

4.7.1.1. **DELIVERABLE:** Adverse Benefit Determination Appeals Report

4.7.1.2. **DUE:** 45 days after the end of the reporting quarter

5. NETWORK DEVELOPMENT AND ACCESS STANDARDS

5.1. Establishing a Network

5.1.1. Contractor shall create, administer, and maintain a network of Network Providers building on the Department's current network of Medicaid Providers, sufficient to provide adequate access to Members for all Covered Services.

5.1.2. Contractor shall maintain a service delivery system that includes mechanisms for ensuring Member access to high-quality, general, and specialized care from a comprehensive and integrated provider network.

5.1.2.1. Contractor may create networks based on quality indicators, credentials, and price.

5.1.3. Contractor shall ensure that its contracted networks are capable of serving all Members, including contracting with Providers with specialized training and expertise across all ages, levels of ability, gender identities, languages, sexual orientations, and cultural identities. Contractor's networks shall include, at minimum, all of the following list of safety net Providers:

5.1.3.1. Public and Private Providers, including independent practitioners.

5.1.3.2. Federally Qualified Health Centers (FQHC).

5.1.3.3. Rural Health Clinics (RHC).

5.1.3.4. School Based Health Centers (SBHC).

5.1.3.5. Indian Health Care Providers.

5.1.3.6. Essential Community Providers (ECP).

5.1.3.7. Providers capable of billing both Medicare and Medicaid.

5.1.4. Contractor shall take the following into consideration, as required by 42 CFR § 438.206, when establishing and maintaining its networks:

5.1.4.1. The anticipated number of Members.

5.1.4.2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented relative to culture, language, and accessibility.

5.1.4.3. The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the covered services.

5.1.4.4. The numbers of participating Providers who are accepting new Members.

5.1.4.5. The number of participating Providers who offer after hour services.

5.1.4.6. The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, Members' access to transportation,

and whether the location provides physical access and accessible equipment for Medicaid Members with disabilities.

5.2. Provider Selection and Contracting

5.2.1. Contractor shall develop and implement a strategy to recruit and retain qualified, diverse and culturally responsive Providers including, but not limited to, Providers who represent racial and ethnic communities, the diversity of gender and sexual identities, the deaf and hard of hearing community, the disability community, and other culturally diverse communities who may be served.

5.2.1.1. Contractor may use mechanisms such as telehealth to address geographic barriers to accessing clinical Providers from diverse backgrounds.

5.2.2. Contractor shall document and post on its public website policies and procedures for the selection and retention of Providers.

5.2.2.1. Contractor shall ensure that its Provider selection policies and procedures, consistent with 42 CFR § 438.12, do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

5.2.3. Contractor shall not discriminate against Providers acting within the scope of the Provider's license or certification under applicable state law, solely on the basis of that license or certification, in accordance with 42 CFR § 438.12(a)(1).

5.2.4. Contractor shall comply with any additional provider selection requirements established by the Department.

5.2.4.1. Contractor may deny Provider selection based on Contractor's own credentialing policies and procedures, so long as Contractor is compliant with requirements established by the Department, at any point during the contracting and credentialing process.

5.2.5. If Contractor declines to include individual or groups of Providers in its Provider network, Contractor shall give the affected Providers written notice of the reason for its decision in accordance with 42 CFR § 438.12.

5.2.6. Contractor shall complete the contracting processes or deny network admission within 90 days after Contractor receives a Provider's written request to contract with Contractor for at least 90% of all Provider requests.

5.2.6.1. Within the 90 day processing timeline, Contractor shall complete the credentialing and contracting processes or deny network admission within 60 days after receiving a completed application.

5.2.6.2. Contractor may deny a Provider's application from the contracting process if a Provider's application is not complete within 80 days after Contractor receives a Provider's written request to contract with Contractor. Contractor shall notify the Provider if the application is not complete prior to denial of the application.

5.2.6.3. The contracting measurement period ends on the actual date of a signed and fully executed contract or when Contractor sends a formal document denying the Provider admission into Contractor's network. The practice of contract backdating does not constitute compliance to this process for the purpose of reporting or meeting the measurement period standards.

5.2.6.3.1. The measurement period may be paused in the event Contractor and the Provider are in active contract negotiations, and Contractor has sent written notice to the Provider that the Provider's application has been approved.

5.2.6.4. Contractor shall respond to all Provider inquiries related to a Provider's application or contract within two business days.

5.2.6.4.1. Contractor shall submit to the Department on a monthly basis the Contracting and Provider Responsiveness Report that includes data on Provider contracting timeliness and responsiveness to Providers using the Department defined format.

5.2.6.4.1.1. **DELIVERABLE:** Contracting and Provider Responsiveness Report

5.2.6.4.1.2. **DUE:** Monthly, on the 15th of the month following the reporting period

5.2.7. Contractor shall document decisions on the admission or rejection of Providers in accordance with Contractor's publicly posted policies and procedures and provide documented decisions to the Department upon request.

5.2.8. Contractor shall ensure that its network includes Providers who meet ADA access standards and communication standards, or Contractor shall offer alternative locations that meet these standards.

5.2.9. Contractor shall allow each Member to choose a PCMP to the extent possible and appropriate.

5.2.10. Contractor shall continually work to expand and enhance the Medicaid networks, including activities such as recruiting new Providers and encouraging Network Providers to expand their capacity to serve more Members.

5.2.11. Contractor shall have policies and procedures describing the mechanisms used to ensure Provider compliance with the terms of this Contract.

5.2.12. Contractor shall document its relationship with and requirements for each Provider in Contractor's network in a written contract.

5.2.13. Contractor shall offer contracts to all willing and qualified FQHCs, Comprehensive Providers, RHCs, and Indian Health Care Providers located in Contractors service area.

5.2.14. Contractor may not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

5.2.15. Contractor shall terminate from Contractor's network any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under title XIX, title XVIII, or title XXI.

5.2.16. To the extent Contractor has a Provider Network, Contractor must permit an out-of- network Indian Health Care Provider to refer an Indian Member to a Network Provider in accordance with 42 CFR § 438.14(b)(6).

5.3. PCMP Network

5.3.1. Contractor shall only enter into written contracts with primary care providers that meet the following criteria to qualify as a PCMP:

5.3.1.1. Enrolled as a Colorado Medicaid Provider.

5.3.1.2. Licensed and able to practice in the State of Colorado.

5.3.1.3. Practitioner holds a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or Nurse Practitioner (NP) provider license.

5.3.1.4. Practitioner is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.

5.3.1.4.1. Behavioral Health Entities and HIV/infectious disease practitioners may qualify as PCMPs with Contractor's approval if all other PCMP criteria are met.

5.3.1.5. The practice, agency, or individual provider, as applicable, renders services utilizing one of the following Provider types:

5.3.1.5.1. Physician (Code 05).

5.3.1.5.2. Osteopath (Code 26).

5.3.1.5.3. FQHC (Code 32).

5.3.1.5.4. RHC (Code 45).

5.3.1.5.5. School Health Services (Code 51).

5.3.1.5.6. Family/Pediatric Nurse Practitioner (Code 41).

5.3.1.5.7. Clinic-Practitioner Group (Code 16).

5.3.1.5.8. Non-physician Practitioner Group (Code 25).

5.3.1.6. Provides Care Coordination.

5.3.1.7. Provides 24/7 phone coverage with access to a clinician that can triage the Member's health need.

5.3.1.8. Has adopted and regularly uses universal screening tools including Behavioral Health screenings, uniform protocols, and guidelines/decision trees/algorithms to support Members in accessing necessary treatments.

5.3.1.9. Tracks the status of referrals to specialty care Providers and provides the clinical reason for the referral along with pertinent clinical information.

5.3.1.10. 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 Services.

5.3.1.11. Uses available data (e.g., Department claims data, clinical information) to identify special Member populations who may require extra services and support for health or social reasons. The PCMP must also have procedures to proactively address the identified health needs.

5.3.1.12. Collaborates with Member, family, or caregiver to develop an individual care plan for Members with complex needs.

5.3.1.12.1. Uses an electronic health record or is working with Contractor to share data with the Department.

5.3.2. Contractor may enter into a written agreement with a primary care Provider to fulfill some of the specific criteria listed above on behalf of a Provider, such as Contractor provides 24/7 phone coverage for a practice or provides Care Coordination for a practice. Contractor shall partner with these PCMPs to identify practice goals and support the PCMPs in working toward achieving these goals.

5.3.3. Contractor shall offer contracts to all willing and qualified PCMP Practice Sites located within Contractor's service area that meet the criteria for being a PCMP.

5.3.3.1. Contractor shall consider each PCMP Practice Site within a health organization, group, or system as a separate PCMP Practice Site for the purposes of the Contactor's PCMP network.

5.3.4. Contractor shall follow all processes established by the Department to ensure that all PCMPs are appropriately affiliated as RAE Network Providers in the interChange system. In addition, Contractor shall submit, in a manner, format and frequency determined by the Department, information relating to all newly contracted PCMPs and Network Providers within contracted PCMP sites.

5.3.5. Contractor shall not restrict the Member's free choice of Providers that deliver family planning services and supplies.

5.3.6. If a female Member's designated primary care physician is not a women's health specialist, Contractor shall provide the Member with direct access to a women's health specialty Provider within the Provider Network for covered routine and preventative women's health care services.

5.3.7. Contractor shall not impose any limitation on a Member's ability to select or change that Member's PCMP that is more restrictive than the Member's right to disenroll from Contractor's limited managed care capitation initiative.

5.3.8. Contractor shall permit any American Indian/Alaska Native Member eligible to receive services from a participating I/T/U Provider, to elect that I/T/U as his or her primary care Provider, if that I/T/U participates in Contractor's network as a primary care Provider and has the capacity to provide the services.

5.3.9. 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.

5.4. Single Case Agreements

5.4.1. Contractor shall enter into Single Case Agreements with willing Providers of Physical Health services enrolled in Colorado Medicaid when Contractor cannot provide a Covered Service through its contracted Provider network within the timeliness standards of this contract and a Member needs access to a Medically Necessary, Covered Service.

5.4.1.1. Contractor shall consider any Physical Health Provider enrolled in Colorado Medicaid for a Single Case Agreement.

5.4.1.2. Contractor may refuse to offer Single Case Agreements based on factors of Provider rate and quality concerns.

5.4.1.3. Contractor shall execute single case agreements within 14 calendar days of a Member's or Provider's submission of a written request for a single case agreement with an identified Provider.

5.4.1.3.1. **PERFORMANCE STANDARD**: 90% of Single Case Agreements shall be executed within 14 calendar days of a Member's or Provider's submission of a written request for a Single Case Agreement with an identified, Medicaid-enrolled Provider.

5.4.1.4. Contractor shall not require Providers that enter into Single Case Agreements to serve additional Members.

5.4.1.5. Contractor shall offer both in- and out-of-network Providers assistance in navigating Contractor's Single Case Agreement Process.

5.4.1.6. Contractor shall ensure all Care Coordination staff and staff who provide Member and Provider support are trained in the Single Case Agreement Process.

5.4.1.7. Contractor shall ensure that all Providers are enrolled in Health First Colorado and are eligible for participation in the Medicaid program, consistent with Provider disclosure, screening, and enrollment requirements, in accordance with 42 CFR § 455.100-106 and 42 CFR § 455.400-470.

5.4.2. Provider Credentialing and Re-credentialing

5.4.2.1. 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 Contractor's timeframes for the credentialing and re-credentialing processes.

5.4.2.1.1. Contractor shall submit the Provider Credentialing Policies and Procedures to the Department in a format to be determined by the Department.

5.4.2.1.1.1. DELIVERABLE: Provider Credentialing Policies and Procedures

5.4.2.1.1.2. DUE: May 1, 2025

5.4.2.2. Contractor shall ensure that all Network Providers are credentialed.

5.4.2.2.1. 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.

5.4.2.2.1.1. Providers who are issued a provisional license and are enrolled with Medicaid are considered to be in good standing.

5.4.2.2.1.2. Contractor shall contract with and reimburse providers with provisional licenses who are enrolled with Medicaid.

5.4.2.2.1.3. Contractor shall use the Council for Affordable Quality Healthcare (CAQH) ProView® application throughout the term of the Contract to collect data from individual Providers as necessary to complete the credentialing and recredentialing processes.

5.4.2.2.1.4. Contractor shall use the CAQH VeriFide™ application throughout the term of the Contract to perform Provider primary source verification for the credentialing and recredentialing processes.

5.4.2.2.1.5. Contractor may not require any additional documentation from individual Providers for the purposes of credentialing, unless the purpose of the request is to obtain a clean file.

5.4.2.2.2. 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.

5.4.2.3. Contractor shall credential all contracted Providers and ensure that re-credentialing of all individual health practitioners occurs at minimum, every three years.

5.4.3. Contractor shall ensure that all laboratory-testing sites providing services under the Contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

5.5. Access to Care Standards

5.5.1.1. Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to include, at minimum, all of the following:

5.5.1.2. Serve all primary care and care coordination needs.

5.5.1.3. Serve all physical health needs.

5.5.1.4. Allow for adequate Member freedom of choice among Providers.

5.5.2. Contractor shall provide the same standard of care to all Members, regardless of eligibility category.

5.5.3. Contractor shall ensure the Provider network is sufficient to support minimum hours of Provider operation to include service coverage from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday.

5.5.4. Contractor's network shall provide for extended hours, outside the hours from 8:00 a.m. to 5:00 p.m., Mountain Time, on evenings and weekends and alternatives for emergency room visits for after-hours urgent care.

5.5.4.1. Contractor shall ensure that evening and weekend support services for Members and families shall include access to clinical staff, not just an answering service or referral service staff.

5.5.5. Contractor shall implement a network management process and maintain an up-to-date database or directory of contracted Network Providers approved to deliver services. Contractor shall ensure that the directory is updated at least monthly and made available to the Department.

5.5.6. Contractor shall ensure that its network provides for 24-hour availability of information, referral and treatment of emergency medical conditions in compliance with 42 CFR § 438.3(q)(1).

5.5.7. Contractor shall ensure that its Provider Network complies with the time and distance standards in the following Table A:

5.5.8. Table A:

Provider Type	Maximum Time (minutes) and Distance Standards (miles)									
	Large Metro County		Metro County		Micro County			Rural County	Counties with Extrem Access Consideration (CEAC)	
	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles)	Time (Minutes)	Dist (Miles
Hospitals (acute care)	20	10	45	30	80	60	75	60	110	100
Primary Care - Adult	20	10	30	15	40	20	60	30	90	60
Primary Care - Pediatric	20	10	30	15	40	20	60	30	90	60
Gynecology, OB/GYN	20	10	30	15	40	20	60	30	90	60
Specialists, Adult	30	15	45	30	80	60	90	75	120	110
Specialists, Pediatric	30	15	45	30	80	60	90	75	120	110
Pharmacy	10	5	15	10	30	20	40	30	70	60

5.5.9. Contractor shall ensure that its Provider Network has a sufficient number of Network Providers per Provider Type listed in Table A so that each Member has a choice of at least two practitioners of the same Provider Type within the maximum time or the maximum distance for the Member's county classification. For Micro, Rural and CEAC areas, the Department may adjust this requirement based on the number and location of available Providers.

5.5.9.1. In the event that there are less than two practitioners that meet the Provider Type standards within the defined area for a specific Member, then Contractor shall not be bound by the requirements of Section 5.5.8 for that Member.

5.5.9.1.1. **PERFORMANCE STANDARD:** At least 90% of Members have choice of at least two Network Providers per Provider Type listed in Table A within the maximum time or the maximum distance for the Member's county classification.

5.5.9.1.2. **PERFORMANCT STANDARD:** At least 95% of Members have at least one Network Provider per Provider Type listed in Table A within the maximum time or the maximum distance for the Member's county classification.

5.5.9.2. Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the Network Providers in Contractor's assigned region(s).

5.5.9.3. Contractor shall ensure that its Provider network meets the following practitioner to Member ratios:

5.5.9.3.1. Adult primary care Providers: One practitioner per 1,200 adult Members.

5.5.9.3.2. Mid-level adult primary care Providers: One practitioner per 1,200 adult Members.

5.5.9.3.3. Pediatric primary care Providers: One PCMP Provider per 1,200 child Members.

5.5.9.3.4. Physician specialist includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology: One Physician specialist per 1,800 Members.

5.5.9.3.4.1. 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.

5.5.9.4. For purposes of Network Adequacy reporting, Contractor shall not include Network Providers that have not provided care to Medicaid Members, measured by not submitting any Medicaid claims, within the previous 18 months.

5.5.9.4.1. Contractor may include as part of Network Adequacy reporting Network Providers that have not submitted any Medicaid claims within the previous 18 months if the Provider attests that they have the capacity and willingness to provide services to Members, but no Members have accessed care with them in the previous 18 months.

5.5.9.5. 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.

5.5.9.5.1. 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.

5.5.10. Contractor may use the Department's template to request an exception from the maximum time and distance standards when a service area has an insufficient number of Providers/facilities to meet the standard network adequacy requirements for a specific Provider type.

5.5.10.1. The Department's approval of an exception on this basis does not relieve Contractor from demonstrating access to the specific service provided by the Provider/facility type that is insufficient in the service area.

5.5.10.1.1. **DELIVERABLE:** Service area Exception

5.5.10.1.2. **DUE:** Upon identification of insufficient Providers/facilities in a service area to meet time and distance requirements

5.5.11. Contractor shall ensure its Provider Network is sufficient so that services are provided to Members on a timely basis, as follows:

5.5.11.1. Urgent Care – within 24 hours after the initial identification of need.

5.5.11.2. Outpatient Follow-up Appointments – within seven calendar days after Member's discharge from a hospitalization.

5.5.11.3. Routine Primary Care, Non-urgent Symptoms – within seven Business Days after the request.

5.5.11.4. Well Care Visit – within 30 calendar days after the Member's request, unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Bright Futures schedule.

5.5.11.5. Contractor shall ensure that Network Providers are not offering services outside of the established timely access to care standards or placing Members on a wait list unless a Member consents. Contractor shall have processes and procedures established with Network Providers for warm hand-offs from the Provider to Contractor so Contractor can support Members in accessing care within the timeliness standards.

5.5.11.6. In collaboration with the Department and other Managed Care Entities, Contractor shall develop and implement a statewide process for monitoring network compliance with the timely access to care standards contained in this Work. This process will be designed in accordance with any available federal guidance.

5.5.11.6.1. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed-upon performance target for SFY 2026-27 and 2027-28 regarding compliance with timely access to care standards. Beginning SFY 2028-29 Contractor shall achieve an aggregate 90% compliance with timely access to care standards as determined by an independent secret shopper survey. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

5.5.12. Contractor shall take actions necessary to ensure that all primary care, Care Coordination, and Physical Health services covered under this Contract are provided to Members with reasonable promptness, including but not limited to the following:

5.5.12.1. Utilization of out-of-network Providers.

5.5.12.2. Using financial incentives to induce network or out-of-network Providers to accept Members.

5.5.13. Contractor shall establish policies and procedures with other RAEs to ensure continuity of care for all Members transitioning into or out of Contractor's enrollment, guaranteeing that a Member's services are not disrupted or delayed.

5.5.14. Contractor shall have a system in place for monitoring patient load in Contractor's Provider network and recruit Providers as necessary to assure adequate access to all covered services.

5.5.15. Contractor shall provide for a second opinion from a Network Provider or arrange for the Member to obtain a second opinion outside the network, at no cost to the Member.

5.5.16. Network Changes and Deficiencies

5.5.16.1. Contractor shall notify the Department, in writing, of Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, timely access to care, or capacity within the Provider network. The notice shall include:

5.5.16.1.1. Information describing how the change will affect service delivery, including total number of Members impacted.

5.5.16.1.2. Availability of covered services.

5.5.16.1.3. A plan to minimize disruption to the Members' care and service delivery.

5.5.16.1.4. A plan to correct any network deficiency, including measurable steps.

5.5.16.1.5. Strategy to provide status updates to the Department.

5.5.16.1.5.1. **DELIVERABLE:** Network Changes and Deficiencies Notice

5.5.16.1.5.2. **DUE:** Within five Business Days after Contractor's knowledge of the change or deficiency.

5.6. Network Adequacy Plan and Reports

5.6.1. Contractor shall create a Network Adequacy Plan as part of the Annual Contracted Network Management Strategic Plan that contains, at a minimum, the following information for both its PCMP and Covered Service Network:

5.6.1.1. How Contractor will maintain and monitor a network of appropriate Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract for all Members, including those with limited English proficiency and Members with physical or mental disabilities.

5.6.1.2. How Contractor will ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

5.6.1.3. Number of Network Providers by Provider type and areas of expertise as defined by the Department, that includes, but is not limited to:

5.6.1.3.1. Adult primary care Providers.

5.6.1.3.2. Pediatric primary care Providers.

5.6.1.3.3. Family planning Providers.

5.6.1.3.4. Gerontologists.

5.6.1.3.5. Internal Medicine Providers.

5.6.1.3.6. Physician Specialist.

5.6.1.4. Number of Network Providers accepting new Members by provider type.

5.6.1.5. Geographic location of Providers in relationship to where Members live.

5.6.1.6. Cultural and language expertise of Providers.

5.6.1.7. Number of providers offering after-hours and weekend appointment availability to Members.

5.6.1.8. Standards that will be used to determine the appropriate case load for providers and how caseloads will be continually monitored and reported to the Department to ensure standards are being met and maintained across Contractor's Provider network.

5.6.1.9. A description of how Contractor's network of Providers and other community resources meet the needs of the Member population in Contractor's assigned region(s), specifically including a description of how Members in special populations are able to access care.

5.6.2. Contractor shall submit a Network Adequacy Report to the Department on a quarterly basis. The Network Adequacy Report shall contain, at a minimum, all of the following information:

5.6.2.1. Number and percent of PCMPs accepting new Members.

5.6.2.2. Number and percent of specialty health Providers accepting new Members.

5.6.2.3. Number and percent of PCMPs offering after-hours appointment availability to Members.

5.6.2.4. Performance meeting timeliness standards.

5.6.2.5. Number of provider single-case agreements used.

5.6.2.6. New providers contracted during the quarter.

5.6.2.7. Providers that left Contractor's network during the quarter.

5.6.2.8. Additional information, as requested by the Department.

5.6.2.9. Providers that have not had an encounter or claim within the previous 18 months and actions Contractor has taken to outreach these Providers.

5.6.3. Contractor shall deliver the Network Adequacy Report to the Department for review and approval.

5.6.3.1. **DELIVERABLE:** Network Adequacy Report

5.6.3.2. **DUE:** Quarterly, on the last Business Day of July, October, January, and April

5.6.4. Network Roster

5.6.4.1. Contractor shall submit to the Department a service Provider roster file in a format determined by the Department.

5.6.4.1.1. **DELIVERABLE:** Monthly Provider Roster

5.6.4.1.2. DUE Monthly, on the last Business Day of the month following the end of the previous months reporting period

6. HEALTH NEIGHBORHOODS

6.1. Contractor shall promote Members' physical, behavioral, and social well-being by creating a Health Neighborhood(s) consisting of a diverse network of health care Providers and community organizations providing services to residents within Contractor's service area.

6.1.1. Contractor shall identify the natural and local communities that exist within Contractor's service area and develop and implement unique Health Neighborhood strategies to coordinate and serve those local communities.

6.1.2. Contractor's efforts shall include increasing Member access to timely and appropriate Medicaid services, state benefits, and community-based resources that can positively impact the conditions in which Members live.

6.2. Health Neighborhood(s)

6.2.1. Contractor shall support the successful engagement and utilization of the full range of Health Neighborhood providers to help Members improve their health and life outcomes, this includes specialty care, Long Term Services and Supports (LTSS) providers, hospitals, pharmacists, dental, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources Centers, and other ancillary Providers. In

addition, the effective leveraging of the Health Neighborhood is a critical tool for controlling costs and wisely utilizing state resources.

6.2.2. Contractor shall establish and enhance relationships among its Network Providers and the Health Neighborhood in the 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.

6.2.2.1. Contractor shall use Contractor's Population Management Strategic Plan to inform Contractor's efforts to manage and coordinate care among diverse networks of health providers and supportive organizations.

6.2.2.2. Contractor shall collaborate with other RAEs to leverage the RAEs' Health Neighborhoods to help serve any of Contractor's enrolled Members who reside within the geographic region of another RAE.

6.2.2.3. Contractor shall collaborate with the Colorado Department of Public Health and Environment, Local Public Health Agencies, Regional Health Alliances, hospitals, Regional Health Connectors, and other organizations in Contractor's service area that have conducted community health needs assessments to focus Contractor's efforts and support the work of these other organizations to fill gaps in care and health-related social needs in the region.

6.2.2.4. Contractor shall identify, leverage, support, and complement existing performance networks operating within Contractor's service area to maximize impact and reduce duplication.

6.2.3. Contractor shall work to increase the number of specialists in the service area who are enrolled as Providers and who are accepting Members.

6.2.3.1. Contractor shall identify barriers to Provider participation in the Health Neighborhood, such as ineffective referral processes, high rates of Member no-shows, ineffective communication or other barriers

6.2.3.1.1. Contractor shall implement programs to address the identified barriers to Provider participation in the Health Neighborhood and to support the efficient use of specialty care resources .

6.2.4. Contractor shall design and implement strategies to engage Providers that are critical to achieving the Department's cost and quality goals for the ACC, Value-Based Payment models, and facility cost and quality indicator programs. Strategies shall include, but are not limited to:

6.2.4.1. Regularly scheduled outreach to specialty care Providers about Contractor and how the specialty care Provider can contact Contractor for assistance in coordinating services for Members.

6.2.4.2. Coordinating services to support Members' engagement in specialty care and reduce administrative burden for specialty care Providers. This may include services such as arranging NEMT, helping coordinate non-medical supports, addressing health-related social needs impacting the Member's condition, following up with Members that miss specialty care appointments, and ensuring the PCMP has shared appropriate clinical information and clinical questions.

6.2.4.3. Leveraging opportunities to share clinical and non-clinical data to facilitate a specialty care Provider's effective and efficient treatment of the Member.

6.2.4.4. Providing support in implementing and utilizing telehealth solutions.

6.2.5. Contractor shall submit a Provider Cost and Quality Goal Engagement Strategy to the Department describing Contractor's plan to engage Providers in the ACC for the upcoming 12 months and a report on the outcomes of Contractor's activities during the previous 12 months.

6.2.5.1. **DELIVERABLE:** Provider Cost and Quality Goal Engagement Strategy

6.2.5.2. **DUE:** Annually, on or before December 31

6.2.6. Contractor shall establish and improve referral processes to increase Member access to appropriate care in the Health Neighborhood and reduce unnecessary utilization of limited specialty care resources.

6.2.6.1. Contractor shall educate Health Neighborhood Providers regarding the utilization of electronic consultation as a method to mitigate incomplete work- ups, reduce inappropriate or unnecessary specialty care visits, and improve timeliness of communication.

6.2.6.2. Contractor shall partner with the Department on facility cost and quality indicator activities, which will offer Members and providers information about the quality of care and patient experience at hospitals and other health care facilities so that Members and Providers can make the most informed decision about where to access their care.

6.2.6.2.1. Contractor shall actively endorse and direct referrals toward the highest- performing facilities as determined by the Department's indicators or other Department approved processes.

6.2.6.2.2. Contractor shall collaborate with the Department to develop best practices that support consistent and comprehensive Network Provider adoption of available tools and cost and quality information to encourage Network Provider referrals to higher preforming facilities and Providers in a way that improves health equity, closes disparities, and improves affordability.

6.2.7. Contractor shall promote the Colorado Crisis Services among Providers and Members to ensure Members receive timely access to Behavioral Health interventions during a crisis.

6.2.7.1. Contractor shall establish arrangements with the Behavioral Health Administrative Service Organizations (BHASOs) and the Colorado Crisis Services vendors and providers for the coordination of follow-up care for Members.

6.2.8. Contractor shall acknowledge that hospitals are an essential part of the health care delivery system and Health Neighborhood and shall have established policies and procedures ensuring collaboration with hospitals to improve care transitions, implement person-centered planning at hospital discharge, and address complex Member needs, including needs of Members with behavioral health and intellectual and developmental disabilities.

6.2.9. Contractor shall utilize and disseminate to appropriate PCMPs and Comprehensive Providers admit/discharge/transfer (ADT) data to track emergency room utilization and improve the quality of care transitions into and out of hospitals. Contractor shall coordinate with hospitals directly or use a HIE to access hospital ADT data.

6.2.10. Contractor shall collaborate with hospitals that are implementing the Hospital Transformation Program that connects hospitals to the Health Neighborhood and aligns hospital incentives with the goals of the ACC.

6.2.10.1. Contractor shall support hospitals in achieving each hospital's chosen projects, interventions, and performance goals for the Hospital Transformation Program.

6.2.11. Contractor shall work with LTSS providers, Case Management Agencies, No Wrong Door Entities, Area Agencies on Aging, and Aging and Disability Resources for Colorado to develop holistic approaches to assisting LTSS Members achieve health and wellness goals.

6.2.12. Contractor shall facilitate health data sharing among Providers in the Health Neighborhood.

6.2.13. Contractor shall establish relationships and communication channels with the entities administering the Department's NEMT benefit in order to ensure Members are able to attend Members' medical appointments on time. Contractor shall designate a single point of contact to lead Contractor's coordination of and collaboration with NEMT. Contractor shall share feedback with the Department on transportation challenges Contractor faces for Contractor's Members and other transportation issues of which Contractor becomes aware.

6.2.13.1. Contractor shall outreach and educate Members to call Contractor's Member call line for help arranging NEMT.

6.2.14. Given the importance of oral health to Members' health and life outcomes, Contractor shall establish relationships and communication channels with the Department's Dental Benefit managed care vendor to promote Member utilization of the dental benefits and identify network adequacy gaps to help the Department's Dental Benefit managed care vendor ensure comprehensive coverage and availability of dental services throughout the region.

6.2.15. Contractor shall collaborate with local public health agencies to:

6.2.15.1. Design opportunities for integration of local public health activities into the ACC.

6.2.15.2. Identify any specific target activities that encourage the prioritization and adoption of initiatives that improve state performance on Medicaid CMS Core Measures and meet the health needs of Members in the region, such as enrollment, health promotion, population health initiatives, and dissemination of public health information.

6.2.15.3. Explore appropriate funding approaches to support collaborative activities.

6.2.16. Contractor shall partner with and align activities with advisory groups, performance networks, specialized programs, and statewide initiatives operating within Contractor's service area to strengthen the health care system and improve Member health. Contractor's partnerships shall include, but not be limited to, the following:

6.2.16.1. BHASOs, funded by BHA to provide Behavioral Health services to vulnerable populations.

6.2.16.2. Colorado Crisis Care, Colorado's statewide resource within the Behavioral Health Administration for mental health, substance use, or emotional crisis help, information and referrals.

6.2.16.3. Colorado QuitLine, Colorado's statewide resource with information about tobacco cessation and free evidence-based tobacco cessation programs.

6.2.16.4. The Department's formal process for proposed benefit coverage policies, which establishes the amount, scope, and duration of fee-for-service benefits, ensures that covered services are evidence-based and guided by best practices, and develops collaborative working relationships with stakeholders.

6.2.16.4.1. Contractor shall recruit Providers and stakeholders, provide input on policies, understand changes to coverage, and educate Providers.

6.2.16.5. Maternity Advisory Committee, a Department committee that reviews program data, provides input on Member quality and experience metrics, and gives recommendations to help improve Member experiences and maternity outcomes.

6.2.16.6. Pharmacy and Therapeutics Committee and Drug Utilization Review Board, which is the Department's process to establish prior authorization criteria for drugs, prescribing guidelines, and the Preferred Drug List for Fee-for-Service.

6.2.16.6.1.

6.3. Health-Related Social Needs and Health and Social Equity

6.3.1. Contractor shall demonstrate an understanding of the health disparities and inequities in their service area and develop plans with Providers, Members and Community Stakeholders to optimize the physical and behavioral health of Contractor's Members.

6.3.2. Recognizing that the conditions in which Members live also impact Members' health and well-being, Contractor shall establish relationships and work jointly with existing community organizations that provide resources such as food, nutrition supports, housing, transportation, interpersonal violence aid, energy assistance, childcare, education, social supports, and job training in the region.

6.3.3. Contractor shall know, understand, and implement initiatives to support local communities to optimize Member health and well-being, particularly for those Members with complex needs that receive services from a variety of agencies.

6.3.3.1. Contractor shall collaborate with school districts, schools and school-based health centers to coordinate care and develop programs to optimize the growth and well- being of Medicaid children and youth.

6.3.4. Contractor shall support Members and Providers with accessing any centralized regional resource directory available listing all community resources available to Members.

6.3.4.1. Contractor shall not duplicate community efforts to create a directory. Instead, Contractor shall integrate, leverage, and participate in any existing state or regional efforts to build a regional resource directory, including, but not limited to, the Social Health Information Exchange (SHIE).

6.3.5. Contractor shall identify and promote Member referrals to and engagement with evidence-based and promising initiatives operating in the region that address health- related social needs, including both community-based organizations and Network Providers engaged in this work.

6.3.6. Contractor shall engage with hospitals, the Colorado Department of Public Health and Environment, local public health agencies, Regional Health Connectors and Regional Health Alliances regarding existing community health needs and assessments to develop, implement and align collaborative strategies to reduce health inequities and disparities in the community.

Strategies shall include attending hospitals' community health needs assessment meetings to ensure that the priorities of the Department, Members, and the Medicaid program are heard and incorporated into the community health assessments.

6.3.6.1. Contractor shall share information with community organizations in the region to support the identification of community social service gaps and needs and the implementation of strategies to address those gaps and needs, with a focus on Department identified priority areas and CMS Core Measure performance.

6.3.7. Contractor shall work in partnership with the Department, other state agencies, and regional and local efforts in order to expand the community resources available to Members.

6.3.8. Health Equity

6.3.8.1. Contractor shall address health equity in Contractor's service area and decrease health disparities for Members from underserved and marginalized communities that include, but are not limited to, racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

6.3.8.2. Contractor shall design and implement strategies to help achieve the goals of the Department's Health Equity Plan while addressing the unique and local community disparities identified by Contractor and Health Neighborhood partners.

6.3.8.2.1. Contractor's activities shall include, but are not limited to, programs aimed at reducing disparities for vaccination rates, maternity and perinatal health, Behavioral Health, and chronic care management and prevention.

6.3.8.3. Contractor shall enhance culturally responsive best practices among staff and Network Providers to improve health equity. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued.

6.3.8.4. Contractor shall document and submit a Health Equity Plan to identify and address specific and targeted health disparities that impact Members within Contractor's service area. The plan shall include an inventory of current and future efforts around health equity to reduce disparity rates and improve health outcomes among Colorado's historically underserved and marginalized communities.

6.3.8.4.1. Contractor shall document in the Health Equity Plan an inventory of current and future efforts around maternity and perinatal health, behavioral health and prevention, and centering health equity to improve health outcomes among Colorado's historically underserved and marginalized communities

6.3.8.4.2. Contractor shall utilize the Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity Priorities in order to organize Contractor's plan, which must include, but is limited to:

6.3.8.4.2.1. Priority 1: Expand the Collection, Reporting, and Analysis of Standardizing Data.

6.3.8.4.2.2. Priority 2: Assess Causes of Disparities within Programs, and Address Inequities in Policies and Operations to Close Gaps.

6.3.8.4.2.3. Priority 3: Build Capacity of Contractor Workforce to Reduce Health and Health Care Disparities.

6.3.8.4.2.4. Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services.

6.3.8.4.2.5. Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage.

6.3.8.4.3. Contractor shall review and update the Health Equity Plan at minimum one time annually, by December 31. The Health Equity Plan shall document Contractor's achievements, successes, challenges, and plans for changes in Contractor's health equity strategy in a format determined by the Department.

6.3.8.4.4. Contractor shall submit the Health Equity Plan to the Department for review and approval.

6.3.8.4.4.1. **DELIVERABLE:** Health Equity Plan

6.3.8.4.4.2. **DUE:** Annually, by December 31

6.3.8.4.5. Contractor shall modify the Health Equity Plan as directed by the Department to account for any changes in the work, in the Department's processes and procedures, in Contractor's processes and procedures, or to address any health equity related deficiencies determined by the Department.

6.3.8.5. Contractor shall post Contractor's Health Equity Plan, including all updates and revisions, on Contractor's public facing website and provide ongoing updates on Contractor's progress on achieving Health Equity Plan goals, including performance metrics.

6.3.8.6. Contractor shall submit relevant Health Equity data to the Department at least two times per year regarding health equity performance in a format determined by the Department.

6.3.8.6.1. DELIVERABE: Health Equity Data

6.3.8.6.2. **DUE:** At least twice per year, on a date determined by the Department

6.3.9. Targeted Health-Related Social Needs

6.3.9.1. Food Insecurity and Nutrition Support

6.3.9.1.1. Contractor shall work with the Department to identify and implement strategic initiatives and best practices consistently across RAEs and Medicaid to improve food security, nutrition support and the related health of Members.

6.3.9.1.2. Contractor shall establish a referral network of community organizations to improve Member access to available food resources and nutrition supports in the Members' communities.

6.3.9.1.3. Contractor shall participate in and align Contractor's activities with advisory groups, existing programs, and statewide initiatives to leverage resources and break down barriers to food access and nutrition support.

6.3.9.1.4. Contractor shall provide training on nutrition assistance programs for Member-facing staff within the first 6 months of employment. This training can be conducted in partnership with a food advocacy organization in the state.

6.3.9.1.5. Contractor may establish partnerships with community organizations to support Members enrollment in the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

6.3.9.1.5.1. Contractor shall coordinate with and inform Contractor's assigned region's State-contracted SNAP outreach and application organization and local county office regarding any planned Member outreach effort regarding food access.

6.3.9.1.6. Contractor shall educate Network Providers on the referral process for WIC, including the use of the online referral form and what information Members are required to provide for WIC eligibility consideration.

6.3.9.1.6.1. Contractor shall educate Network Providers to provide anthropometric data (e.g., height, weight, and hemoglobin) to Members to reduce barriers to Member enrollment in WIC.

6.3.9.2. Housing Insecurity

6.3.9.2.1. Services for the Homeless

6.3.9.2.1.1. Contractor shall identify Members who are actively homeless, at-risk of homelessness, or have a history of homelessness using, at a minimum, Department-provided data, data from the Continuums of Care, and data on housing needs from social need screenings.

6.3.9.2.1.2. Contractor shall provide care coordination to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

6.3.9.2.1.2.1. Contractor shall establish relationships with regional Continuum of Care partners and report on those partnerships in the Health Neighborhood Report.

6.3.9.2.1.2.2. Contractor shall establish partnerships with and collaborate with community organizations and other on-the-ground agencies to reach Members and support outreach efforts.

6.3.9.2.1.3. Contractor shall partner with local housing organizations, including but not limited to organizations who are part of the Coordinated Entry System, to support, at a minimum, the delivery of the following types of assistance for Members who are homeless or at risk of homelessness:

6.3.9.2.1.3.1. Identifying housing options for Members at risk of experiencing homelessness, such as emergency shelter and temporary or bridge housing.

6.3.9.2.1.3.2. Assisting Members in filing applications for housing and gathering necessary documentation.

6.3.9.2.1.3.3. Coordinating the provision of supportive housing.

6.3.9.2.1.3.4. Coordinating housing-related services.

6.3.9.2.1.4. Contractor shall be a member of the regional Continuums of Care and participate in stakeholder meetings and case conferencing meetings, as necessary.

6.3.9.2.2. Permanent Supportive Housing (PSH)

6.3.9.2.2.1. Contractor shall maintain or partner with a network of PSH providers in the region. Contractor shall support the enrollment of PSH providers as Colorado Medicaid providers through contracting and network development efforts.

6.3.9.2.2.2. Contractor shall ensure the clinical services, particularly Behavioral Health services, are provided to Members who are qualified for and enrolled in PSH, especially during the period a Member is waiting to move into a permanent housing arrangement.

6.3.9.2.2.2.1. Contractor shall ensure Care Coordination services for Members qualified for PSH are documented and reported to the Department in the Health Neighborhood Report or through another mechanism as determined by the Department.

6.3.9.2.2.2.1.1. Contractor shall report the number of Members who qualified for but who are not yet enrolled in PSH who received Care Coordination services from Contractor.

6.3.9.2.2.2.1.2. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed-upon performance target for the percentage of Members who are enrolled in PSH but are waiting to move into a permanent housing arrangement who received Care Coordination from Contractor or Contractor's delegated Subcontracted entities during the previous quarter. Contractor shall not be held accountable for this Performance Standard prior to SFY 2026-27 or later as determined by the Department.

6.3.9.2.2.2.2. Contractor shall report on number of Members enrolled in PSH who received Care Coordination services from Contractor.

6.3.9.2.2.3. Contractor shall coordinate with PSH Providers who provide management to ensure referrals occur when needed, specifically to physical and Behavioral Health services.

6.4. Health Neighborhood Report

6.4.1. Contractor shall submit a report, twice per Fiscal Year, to the Department describing Contractor's activities to collaborate with and build the Health Neighborhood to support Members' health care and social needs, in addition to articulating plans for the Health Neighborhood in the Annual Network Management Strategic Plan.

6.4.1.1. Contractor shall submit the Health Neighborhood Report to the Department in a format agreed upon by the Department and Contractor.

6.4.1.1.1. **DELIVERABLE:** Health Neighborhood Report

6.4.1.1.2. **DUE:** Every 6 months, by August 15 and February 14

7. POPULATION MANAGEMENT

7.1. Contractor shall utilize a population management approach to manage Contractor's overall Member population, identify, and manage health and health-related social needs, address health disparities, and achieve better health outcomes while reducing unnecessary costs and services.

7.2. Contractor's population management approach shall align with the Department's goals and objectives and include at a minimum, all of the following components:

7.2.1. Member engagement strategies.

7.2.2. Provider engagement and support.

7.2.3. A full range of clinical and non-clinical interventions.

7.2.4. Evidenced-based programs and promising practices designed to promote wellness, improve overall Member health, and prevent disease progression.

7.2.5. Comprehensive care coordination.

7.3. Contractor shall provide evidence based, industry standard condition management programming, including interactive Member technology solutions, that utilize an established curriculum or protocol designed to address common health conditions, including, but not limited to, Maternity, Diabetes, Hypertension, Asthma, and COPD.

7.3.1. Contractor shall develop programs to manage and support Members with specific health conditions when Contractor or the Department has identified gaps in care and programming to meet Member needs based on current data trends or claims information. Contractor shall prioritize health conditions for which its Network Providers do not have existing programs.

7.3.2. Contractor shall submit a Condition Management Report in a format determined by the Department and Contractor. The Condition Management Report shall include data on Member engagement in Contractor's Condition Management programs.

7.3.2.1. **DELIVERABLE:** Condition Management Programming Report

7.3.2.2. **DUE:** February 14, 2026 and then every 6 months by August 15 and February 14

7.4. Contractor shall describe Contractor's population management approach in a Population Management Strategic Plan in a format determined by the Department.

7.4.1. The Population Management Strategic Plan shall, at a minimum, describe all of the following:

7.4.1.1. Member engagement strategies.

7.4.1.2. The range of clinical and non-clinical interventions to be offered to Members and the correlating evidence-base as appropriate.

7.4.1.3. Contractor's strategy to use predictive modeling analytics or software to target impactable populations.

7.4.1.4. Contractor's strategy for including Members, Network Providers and Health Neighborhood providers and organizations as described in Section 6 in the development of the Population Management Strategic plan and supporting partners in the implementation of the overall population management approach.

7.4.1.5. Contractor's approach to monitor and assess the effectiveness of the population management approach, including the identification of population management specific metrics.

7.4.2. Contractor shall submit the Population Management Strategic Plan to the Department for review and to integrate feedback as appropriate.

7.4.2.1.1. **DELIVERABLE:** Population Management Strategic Plan

7.4.2.1.2. **DUE:** Annually, on or before July 1

8. CARE COORDINATION

8.1. Overview

8.1.1. Contractor shall ensure whole person Care Coordination and case management (referred to collectively as Care Coordination) is available to and provided for all enrolled Members.

8.1.2. Contractor shall implement a comprehensive Care Coordination program that addresses the full range of Members' physical health, Behavioral Health, oral health, and health-related social needs as part of Contractor's overall population health management strategy.

8.1.3. Contractor's comprehensive Care Coordination program shall support the delivery of Care Coordination activities at the point of care and by those entities who have the strongest relationship with or most consistent engagement with a Member.

8.1.3.1. Contractor's comprehensive Care Coordination program shall include Care Coordination activities delivered by Contractor, Network Providers, and other state and community partners that may include CBOs and entities that are funded by other state agencies for related or complementary work.

8.1.3.2. Contractor shall be accountable for ensuring appropriate Care Coordination services are provided to Members regardless of who is providing Care Coordination.

8.1.4. Contractor shall develop and implement strategies and tools that provide the Department with information to understand and monitor how Members are receiving Care Coordination within Contractor's service area, whether provided by Contractor, Contractor's Network Providers, subcontractors, or other delegated or contracted arrangements with regional partners.

8.1.4.1. Contractor's Care Coordination program shall have the goals of:

8.1.4.1.1. Preventing disease progression through interventions that target physical, behavioral, and oral health as well as health-related social needs.

8.1.4.1.2. Reducing unnecessary, avoidable, and duplicative Care Coordination, service utilization, and costs.

8.1.4.1.3. Improving coordination of care and reducing gaps in care across Medicaid programs and State benefits.

8.1.4.1.4. Improving Members' experience of care.

8.2. Care Coordination Activities

8.2.1. Contractor shall work with the Department to standardize aspects of the delivery of Care Coordination within a three-tiered model that categorizes the types of Care Coordination services that should be made available for Members based on Member acuity and identifies criteria for stratifying Members into each tier. Contractor shall implement the Care Coordination program in compliance with the Department approved and documented guidance regarding the Care Coordination three tier model.

8.2.1.1. During the Start-up Period, Contractor shall collaborate with the Department to modify the Department's three-tiered Care Coordination model, in advance of the Operational Start Date.

8.2.1.2. Contactor may incorporate Contractor's own unique Member stratification requirements within the guidelines established by the Department to achieve Contractor's specific goals based on Contractor's analysis of Contractor's Members.

8.2.1.3. Contractor shall allow Contractor's clinical Care Coordination staff the discretion to move Members in and out of tiers based on clinical assessment of Members, organic referrals from entities serving Members directly, Member requests, and in line with Member needs and preferences, regardless of a Member's diagnosis.

8.2.2. Contractor's Care Coordination program shall consist of the following three tiers:

8.2.2.1. Tier 1 Care Navigation – for all Members, with an emphasis on prevention and wellness promotion and education: Contractor shall oversee the implementation of proactive and responsive education and benefit navigation that assists Members in accessing evidence-based preventive care services, and navigating the Medicaid system.

8.2.2.2. Tier 2 Care Coordination – for all Members with rising risk: Contractor shall oversee that interventions are in place (including but not limited to Condition Management programming to prevent Members with rising risk from requiring higher levels of care.

8.2.2.3. Tier 3 Care Management – for Members with complex needs: For Members with multiple conditions, complex health and social needs, and high utilization, Contractor shall oversee that Members receive appropriate longitudinal evidence-based and proven programs that involve multi-disciplinary care approaches to maintain or improve Member health.

8.2.2.3.1. Contractor shall document in the Annual Population Management Strategic Plan how Contractor proposes to manage Care Coordinator to Member ratios for Members who have agreed to Care Coordination, including how ratios account for factors which may include, but are not limited to, Care Coordinator credentials/specialization, Member sub-populations, and whether or not caseloads are defined by tier or include a blend of tiers.

8.2.3. Care Coordination Activities

8.2.3.1. Contractor shall ensure that, at a minimum, the following Care Coordination activities are available to Members based on a Member's need:

8.2.3.1.1. Outreach and health promotion of evidence-based preventive care.

8.2.3.1.1.1. Contractor shall implement creative engagement strategies in collaboration with local partners, including CBOs, for Members who are not engaging in care.

8.2.3.1.1.2. Contractor shall promote a comprehensive or periodic oral evaluation at least one time annually for all Members.

8.2.3.1.1.2.1. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed-upon performance target that is not less than the previous three-year average on the dental visit engagement rate.

8.2.3.1.2. Screening for short- and long-term health needs using evidence-based tools, including physical health, Behavioral Health, oral health, and Health Related Social Needs.

8.2.3.1.3. Referrals to resolve Members' identified needs, including follow up to ensure the closure of referral loops.

8.2.3.1.3.1. Contractor shall utilize the SHIE and related systems to improve coordination of services addressing Health Related Social Needs.

8.2.3.1.4. Documentation of care plans.

8.2.3.1.4.1. For Members in the Tier 3 Care Management, Contractor shall have policies and procedures to monitor and support whether comprehensive care plans are established within 90 days after Member consents to Care Coordination and updated at least twice a year for as long as the Member remains actively engaged in Tier 3 Care Management.

8.2.3.1.4.2. Contractor shall ensure comprehensive care plans for Members in Tier 3 Care Management contain, at minimum:

8.2.3.1.4.2.1. Measurable, time-bound, relevant Member-identified goals for whole- person care.

8.2.3.1.4.2.2. List of all entities and individuals involved in the Member's care, including identification of the lead care coordinator.

8.2.3.1.4.2.3. Agreed upon frequency of engagements with the Member and/or their care team.

8.2.3.1.4.2.4. The lead care coordinator may be a care coordinator/case manager from another entity that provides support around the Member's identified primary needs and serves as the Member's primary point of contact.

8.2.3.1.4.2.5. Member-specific criteria for successful discharge from Care Coordination.

8.2.3.1.4.3. In cases where another agency's care coordinator/case manager has been identified as the lead (e.g., High-Fidelity Wraparound or a CMA), Contractor shall follow and complement the goals of the other agency's care plan to avoid duplication.

8.2.3.1.4.3.1. Contractor shall document a copy or key elements of a lead agency's care plan in Contractor's Care Coordination platform for Members in Tier 3 Care Management.

8.2.3.1.4.3.2. **PERFORMANCE STANDARD**: Contractor shall ensure that a minimum of 25 care plans per 1000 assigned Members per year are created for Members eligible for Tier 3 Care Management.

8.2.3.1.5. Regular meetings between the Member and the Member's care team and/or care coordination team at appropriate intervals to meet the Member's goals and in accordance with established care/treatment plans.

8.2.3.1.5.1. Contractor or its designee shall take responsibility for convening and facilitating multi-provider or multi-agency care teams when no other provider or agency is identified as the lead care coordinator for a Member and when determined necessary

by Contractor, its subcontractors or delegates, Network Providers, or a partner agency such as a county.

8.2.3.1.5.2. For Members in Tier 3 Care Management, Contractor shall ensure Members have regular engagement, at minimum of one time a month, with the Member's care coordinator and/or care team as agreed upon between Contractor and the Member or care team and documented in the care plan.

8.2.3.1.5.3. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed upon performance target for Members eligible for Tier 3 Care Management that received a Care Coordination engagement activity or care team visit per 1,000 assigned Members per year. Contractor shall not be held accountable for this Performance Standard prior to SFY 2026-27 or later as determined by the Department.

8.2.3.1.6. Coordination of care transitions for Members moving between levels of care.

8.2.3.1.7. Clinical case management for Members with complex health and social needs, including involvement with multiple agencies.

8.2.3.1.7.1. Contractor or its designated care coordinators shall participate in multi- provider care teams and, as appropriate, multi-agency care teams for Members with co-occurring physical and/or Behavioral Health conditions and/or Members who receive services from various state agencies.

8.3. Care Coordination Approach

8.3.1. Contractor shall oversee that the full continuum of appropriate Care Coordination interventions are occurring for Members, whether delivered by Contractor, Network Providers, or by delegated or subcontracted entities.

8.3.2. Contractor's Care Coordination program shall meet the following characteristics:

8.3.2.1. Person and family-centered.

8.3.2.2. Trauma informed.

8.3.2.3. Accessible and inclusive.

8.3.2.4. Culturally Responsive.

8.3.2.5. Delivered at the point of care to the extent possible, leveraging Network Providers, Local Public Health Agencies, and CBOs.

8.3.2.6. Evidence-based.

8.3.2.7. Respectful of Member choice, including but not limited to:

8.3.2.7.1. Allows for Members to choose to replace their care coordinator, regardless of reason, barring extenuating circumstances.

8.3.2.7.2. Is delivered through multiple modalities as appropriate for a Member's needs and communication preferences (e.g., mobile, in-home, online, in community, telephonic).

8.3.2.8. Supports timely and consistent communication between the care coordinators, the providers delivering services to Members, the Member, and the Member's care team.

8.3.3. Contractor shall utilize a continuum of para-professional and licensed clinical care coordinators (e.g., Registered Nurses, Social Workers, Community Health Workers, Navigators, and Clinical Leads) to appropriately address Members' unique needs.

8.3.3.1. Contractor shall ensure care coordinators have the appropriate level of knowledge of different systems and settings to serve specific populations and solve Care Coordination problems for those populations, 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.

8.3.3.2. Contractor shall ensure Care Coordination staff have knowledge of the Department's Fee-for-Service physical health benefits including, but not limited to, the Department's policies and associated rules for out-of-state care, NEMT, and in- home benefits such as private duty nursing, long-term home health, and personal care.

8.3.4. Contractor shall reduce duplication of efforts and overburdening Members and Providers by leveraging existing screenings, assessments, and care plans collected by other entities in the Health Neighborhood to the extent possible.

8.3.5. Contractor shall follow Department guidance for coordinating care for Members shared with other organizations/entities.

8.3.6. Contractor shall comply with Department requirements for coordinating care for Members identified for special initiatives, including but not limited to:

8.3.6.1. Children and youth eligible for the Child and Youth Medicaid System of Care.

8.3.6.2. Members eligible for services through any Department 1115 Waiver.

8.3.6.3. Members identified as At-Risk for Institutionalization and At-Risk Transition resulting from an agreement with the Department of Justice.

8.3.6.3.1. Contractor shall process a Department list of Members who are identified as At- Risk for Institutionalization and Diversion and outreach the identified Members within 10 Business Days of processing the Department list to provide, at a minimum, s, care transition support, information and referrals to community-based resources, and/or referrals to HCBS services.

8.3.6.4. Members who are transplant recipients with an SUD diagnosis.

8.3.6.4.1. Contractor shall follow the transplant patients with SUD Diagnosis protocol developed by the Department, including but not limited to making resources easily accessible on Contractor's website for hospital transplant teams to coordinate services.

8.3.7. Contractor shall comply with the Department's transition of care policy to ensure Member's continued access to services during a transition from one RAE to another RAE as required in 42 CFR § 438.62, including but not limited to a warm handoff initiated by the original care coordinator.

8.3.8. Contractor shall possess capabilities to leverage and build upon the Department's data systems to perform analytics of both Contractor's and the Department's data to successfully implement an information-based approach to delivering and coordinating care and services across the continuum.

8.3.9. Care Coordination Subcontract/delegation

8.3.9.1. Contractor may subcontract or delegate Care Coordination activities but shall be responsible for ensuring any subcontracted or delegated entity/Provider meets the appropriate Contract Performance Standards and Reporting Requirements.

8.3.9.1.1. Contractor's subcontracted or delegated arrangements may include organizations representing a network of providers, PCMPs, or community organizations.

8.3.9.1.2. Contractor shall be responsible for monitoring organizations and Providers who have been Subcontracted or delegated Care Coordination responsibilities.

8.3.9.1.3. Contractor shall provide any Care Coordination activities not offered by the delegated or subcontracted Care Coordination entity at no cost.

8.3.9.2. Contractor shall submit a comprehensive list of the subcontracted and delegated Care Coordination entities and providers who are responsible for any Work involving delivery of Care Coordination for Members to the Department for review and approval.

8.3.9.2.1. Contractor shall define the relationship between Contractor and each subcontracted and delegated Care Coordination entity and Provider, including which is responsible for what forms of Care Coordination and for which Members.

8.3.9.2.1.1. **DELIVERABLE:** Care Coordination Roles Report

8.3.9.2.1.2. **DUE:** Annually, as part of the Annual Population Management Strategic Plan, and within 30 calendar days after any change to a subcontracted or delegated relationship

8.4. Coordinating Care Transitions

8.4.1. Contractor shall develop and implement care transitions policies and procedures that expedite successful transitions and discharges by arranging and coordinating Medically Necessary on-going treatment and services addressing Members' health and health-related social needs while preventing unnecessary readmissions and/or ED visits, utilization of the wrong level of care, and other adverse health outcomes.

8.4.1.1. Contractor's policies and procedures shall incorporate evidence-based models and align with Department programs, including but not limited to the Hospital Transformation Program (HTP), Inpatient Hospital Transitions (IHT), and Creative/Complex Solutions.

8.4.1.2. Contractor's policies shall describe how it will manage care transitions from a broad array of services, including but not limited to physical and behavioral health hospitals, residential programs, EDs, 72-hour holds, nursing facilities, and crisis services supports.

8.4.1.3. Contractor shall have documented processes for handling discharges from out-of-state hospitals and residential programs.

8.4.2. Contractor shall have documented policies and procedures in place for Contractor to conduct care transition activities or to monitor Network Providers' delivery of care transition activities.

8.4.3. Contractor shall have processes to monitor that care transition best practice activities are being implemented by the discharging entity, the Member's care team, or other appropriate entities.

8.4.3.1. Contractor shall have processes to confirm Members have successfully engaged with services and supports as identified in the Member's discharge plan, as well as processes to follow up with the Member if they have not engaged.

8.4.3.2. Contractor shall ensure that care transitions provided by Contractor do not duplicate the efforts of the discharging/transitioning entity but should concentrate on implementing and monitoring the plan for the Member once they are ready for transition/discharge.

8.4.3.3. Contractor shall collaboratively establish policies and procedures, which could consist of a business associate agreement (BAA), memorandum of understanding (MOU), or Data Sharing Agreement, with physical and Behavioral Health hospitals, residential programs, nursing facilities, and crisis providers regarding care transition services that meet the unique needs and requirements of individual settings and systems and avoids duplication of services. The agreed upon policies and procedures shall address the following minimum information.

8.4.3.3.1. Communication and data sharing procedures, including but not limited to a process to identify Members ready to transition.

8.4.3.3.2. Defined roles and responsibilities for Member discharge/transition planning, including timeframes as appropriate.

8.4.4. Contractor shall review relevant data feeds every Business Day to prioritize care transition support, including but not limited to:

8.4.4.1. ADT data from all Colorado Health Information Exchange platforms.

8.4.4.2. IHT feeds.

8.4.5. Contractor shall document in Contractor's Care Coordination platform and/or obtain from the discharging/transitioning entity the discharge plan, crisis follow-up plan, safety plan, IHT documentation, and other relevant care plans or documentation.

8.4.6. Contractor shall ensure care transitions within Contractor's assigned region(s) follows best practices that include, at minimum, all of the following:

8.4.6.1. Initiation of collaboration with the hospital, residential program, or crisis supports, and the Member and/or the Member's caregivers, as soon as possible to prepare for successful transition.

8.4.6.2. Notification of the Member's care team of an admission/encounter.

8.4.6.3. Outreach to the Member and/or the Member's caregiver within two Business Days following notification to Contractor of discharge/transition to:

8.4.6.3.1. Ensure a follow up appointment with a licensed health care Provider has been scheduled following discharge/transition within the following parameters:

8.4.6.3.1.1. 30 days for physical health, especially when discharged from a hospital.

8.4.6.3.1.2. Seven days for Behavioral Health, especially when discharged from a hospital.

8.4.6.3.2. Support the Member with scheduling a follow-up appointment with a licensed health care Provider if no appointment exists.

8.4.6.3.3. Coordinate support and resources, including but not limited to transportation, so that Member can attend the Member's follow up appointment.

8.4.6.3.4. Complete medication review or confirm completion of medication review, if applicable to Member's care plan. Contractor shall facilitate warm hand-off to Member's care team if there are questions regarding medication.

8.4.6.4. Obtain a copy of the Member's discharge plan, and in the case of a Behavioral Health discharge/transition, a copy of the Member's crisis plan, or discuss a Member's discharge plan with the entity overseeing a Member's discharge to identify any actions Contractor may need to take to assist with a successful transition. Contractor shall document the reason when a discharge plan was not made available to Contractor or Contractor was unable to discuss the discharge plan with the entity overseeing a Member's discharge in order to identify and address systemic issues that may be contributing to unsuccessful care transitions.

8.4.6.5. Notification of the Member's care team of the Member's discharge/transition.

8.4.7. Upon Department request, Contractor shall make available adequate and appropriately trained clinical Care Coordination staff (e.g., nurses, social workers, or physicians) with experience in addressing a Member's needs.

8.4.8. Contractor shall actively work with ED, residential, and inpatient facilities to facilitate timely Member discharge.

8.4.9. Contractor shall work with the Department, BHA, and other relevant state agencies to review cases of Members that have been indicated as posing difficulties for returning back to the community and develop an agreed-upon transition plan. Contractor shall identify barriers to discharge and develop an appropriate transition plan back to the community.

8.4.9.1. Contractor shall regularly report on Members experiencing challenges to discharge from hospitals, in a format determined by Department.

8.4.9.1.1. **DELIVERABLE:** Weekly Hospital Discharge Status Report

8.4.9.1.2. **DUE:** Weekly, on a day of the week determined by Department

8.4.9.1.3. Contractor shall submit IHT Reports to the Department quarterly using a Department template.

8.4.9.1.3.1. **DELIVERABLE:** IHT Report

8.4.9.1.3.2. **DUE:** Quarterly, as determined by the Department

8.4.10. ED Utilization and Readmissions

8.4.10.1. Contractor shall have a documented plan to identify Members who are overutilizing the ED or experiencing multiple readmissions for both physical health and behavioral health needs and shall employ outreach strategies to determine the cause. Contractor shall offer education and other appropriate interventions to Members to reduce inappropriate ED utilizations or unnecessary readmissions.

8.4.10.2. Contactor's plan for physical health shall include, but is not limited to:

8.4.10.2.1. Measurable strategies to reduce 30-day, 90-day, and 180-day repeat ED visits and hospital readmission rates attributed to physical health concerns.

8.4.10.2.2. Contractor's approach to ensuring Members experiencing readmissions or repeated ED utilization are receiving Care Coordination that, at a minimum, assists Member access to recommended outpatient treatments and medications to support the Member's progress on achieving the Member's physical health goals.

8.4.10.2.3. Policies for reviewing Member specific data with the Member's Providers, which may include the Member's PCMP and other Condition Management Programs, as applicable.

8.4.10.3. Contractor's plan for behavioral health shall include, but is not limited to:

8.4.10.3.1. Measurable strategies to reduce 30-day, 90-day, and 180-day readmission rates in residential and inpatient treatment settings for mental health and SUD.

8.4.10.3.2. Strategy for monitoring the 30-day, 90-day, and 180-day readmission rates to:

8.4.10.3.2.1. Colorado's Mental Health Hospitals.

8.4.10.3.2.2. Freestanding Psychiatric Hospitals.

8.4.10.3.2.3. PRTFs.

8.4.10.3.2.4. QRTPs.

8.4.10.3.2.5. Residential and inpatient treatment Providers of SUD.

8.4.10.3.3. Measurable strategies to reduce repeated ED utilization rates attributed to mental illness and SUD.

8.4.10.3.4. Contractor's approach to exhausting all reasonable efforts to ensure Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Covered Services after discharge from residential, inpatient, or ED care due to a Behavioral Health reason, with sufficient frequency and amounts to support the Member's progress on achieving the Member's Behavioral Health goals.

8.4.10.3.5. Policies for reviewing Member specific data with the Member's Providers, which may include the Member's PCMP and other Mental Health or SUD Treatment Programs, as applicable.

8.4.11. Colorado Mental Health Hospitals and Freestanding Psychiatric Hospital Transitions

8.4.11.1. Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Colorado mental health hospitals and Freestanding Psychiatric Hospitals to safe and alternative environments.

8.4.11.2. Contractor shall participate in discussions and Care Coordination with the Colorado Mental Health Hospitals and Freestanding Psychiatric Hospitals.

8.4.11.3. Contractor shall work with the Colorado Mental Health Hospitals to execute communication and transition plans for Members.

8.4.11.4. Contractor shall designate a liaison to assist in facilitating a coordinated discharge planning process for Members admitted to Colorado Mental Health Hospitals or private Freestanding Psychiatric Hospitals.

8.4.11.4.1. Contractor's liaison shall assist and collaborate with the applicable Network Provider to expedite discharge and engagement in ongoing Covered Services.

8.4.11.4.2. Contractor shall actively assist the Colorado mental health hospitals and private Freestanding Psychiatric Hospitals treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable state and federal regulations.

8.4.11.4.3. Contractor shall actively participate with and assist Colorado mental health hospitals and other private Freestanding Psychiatric Hospitals staff in the development of a written discharge plan within one Business Day after a Member's admission.

8.4.11.4.4. Contractor shall ensure Members are scheduled for an appointment with an appropriate mental health clinician and that transportation has been arranged for the appointment prior to discharging a Member. Such appointment shall occur within seven calendar days after a Member's discharge.

8.4.11.4.4.1. Contractor shall have policies and procedures to exhaust all reasonable efforts to ensure that Members receiving Assertive Community Treatment (ACT) team services are seen by the applicable Provider within one Business Day after the Member's discharge.

8.4.11.4.5. Contractor shall implement policies and procedures to support the provision of the discharge progress note to the aftercare Provider prior to a Member's discharge.

8.4.11.4.5.1. For ACT team service recipients, Contractor shall have policies and procedures to support the Colorado mental health hospitals and other private Freestanding Psychiatric Hospitals in providing the discharge progress note to the ACT Provider, within 24 hours after a Member's discharge.

8.4.11.4.6. Contractor shall ensure Members have been outreached within 72 hours after the Member's discharge from Colorado Mental Health Hospitals, Freestanding Psychiatric Hospitals, or other facility identified as an IMD in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

8.4.11.4.6.1. **PERFORMANCE STANDARD:** Contractor shall ensure that 95% of Members discharged from Colorado Mental Health Hospitals, Freestanding Psychiatric Hospitals, or other facility identified as an IMD have been outreached within 72 hours after the Member's discharge.

8.4.12. Crisis System Transitions

8.4.12.1. Contractor shall collaborate with the BHASOs and Colorado Crisis System, including but not limited to Mobile Crisis Response Provider(s), in Contractor's assigned region to facilitate timely notification of Contractor, timely follow-up outreach, and timely treatment for enrolled Members who have accessed crisis services.

8.4.12.2. Contractor shall have documented processes in place to identify and support Members who frequently make contact with crisis system providers.

8.4.12.3. Contractor shall require mobile crisis response Providers outreach Members within five calendar days after onset of a Member's crisis episode in order to support the Member in attending any scheduled follow-up appointments..

8.4.12.3.1. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed upon performance target for Members who have had contact with a mobile crisis response Provider that have been outreached within five days of the Member's initial contact with the mobile crisis response provider. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

8.5. Collaborations for Coordinating Care for Shared Members

8.5.1. Contractor shall establish documented policies and procedures to facilitate effective collaboration, communication, and coordination with state and county agencies and programs, Providers, health plans, and community organizations serving shared Members.

8.5.2. Contractor's collaborative arrangements may be documented informally or through formal vehicles such as a BAA, MOU, data-sharing agreement, or Subcontracting relationship.

8.5.2.1. Contractor's collaborative arrangements shall address, but not be limited to, the following:

8.5.2.1.1. A brief definition/overview of the collaborative work responsibilities.

8.5.2.1.2. Standards, processes, and workflows for cross-agency communication and coordination in various areas, which may include, but is not limited to regular meetings, training, Member outreach, Member referrals, case consultations, and transitions of care, as appropriate.

8.5.2.1.3. Roles and responsibilities, including which program will take on the role as lead care coordinator.

8.5.2.1.4. Data sharing, whenever possible and appropriate, and analysis protocols.

8.5.2.1.5. A process for escalating concerns when necessary.

8.5.3. Contractor may offer collaborating organizations access to Contractor's care coordination platform, as deemed appropriate, and develop a data sharing agreement with the entity to ensure Contractor is able to report on required Care Coordination metrics, including meaningful engagement in Care Coordination.

8.5.4. Community Based Organizations (CBOs)

8.5.4.1. Contractor shall strengthen and support a network of local CBOs in order to identify and engage with Members who are unreachable through conventional methods (e.g., phone, text, mail) and/or Members who underutilize preventive care, case management, and condition support programs in an effort to improve equitable access to care, quality outcomes, and affordability.

8.5.4.2. Contractor shall identify appropriate CBOs in Contractor's service area that may include, but are not limited to food banks, shelters, community centers, and agencies supporting

marginalized Members (such as covered immigrants, refugees, indigenous peoples, individuals experiencing homelessness, etc.).

8.5.4.3. Contractor shall prioritize CBOs that employ Community Health Workers who are registered through the Department of Public Health and the Environment but that are ineligible for Medicaid reimbursement.

8.5.4.4. Contractor may provide financial support to CBOs for conducting outreach, health promotion, and Care Coordination for Contractor's Members.

8.5.4.5. Contractor may co-locate Contractor's own care coordinators or train existing CBO staff to conduct Care Coordination activities with support and guidance from Contractor, especially for Members who face health inequities and those Members who would benefit from support in Tier 2 Care Coordination or Tier 3 Care Management.

8.5.4.6. Contractor shall leverage existing environmental scans, the Department's and Contractor's Health Equity Plan, and data collected by other state agencies to determine which locations and populations to focus on within service area.

8.5.4.7. Contractor shall track the number of referrals to Care Coordination generated through Contractor's CBO network and as requested by the Department, deliver a Care Coordination report on a template provided by the Department.

8.5.4.7.1. **DELIVERABLE:** CBO Care Coordination Report

8.5.4.7.2. **DUE:** As requested by the Department

8.5.5. Case Management Agencies (CMAs)

8.5.5.1. Contractor shall establish and maintain strong and ongoing relationships with all CMAs serving shared Members in accordance with guidance provided by the Department. Contractor shall collaborate with the Department and CMAs to review and update this guidance at least one time annually.

8.5.5.2. Contractor shall establish a dedicated email address and phone line for CMAs in the service area to submit information, questions, share updates, etc.

8.5.5.3. Contractor shall respond to CMAs in a timely manner, no longer than two Business Days, to ensure Members needs are addressed.

8.5.5.4. Contractor shall set regularly occurring meetings with its CMA Partners that include but are not limited to:

8.5.5.4.1. Monthly check-ins or huddles.

8.5.5.4.2. Regular caseload reviews.

8.5.5.5. Contractor shall utilize the Department's Care and Case Management tool utilized by the CMAs to monitor Member activities to the extent possible.

8.5.5.6. Contractor shall have documented processes for performance improvement regarding Contractor's collaboration with CMAs to monitor and implement necessary improvements.

8.5.5.7. Contractor shall participate in Department-led activities to improve oversight and monitoring. These activities may include, at minimum, the following:

8.5.5.7.1. Regularly participating in the CMA-RAE Cross Agency Forum

8.5.5.7.2. Creating and participating in cross-functional group meetings to review data and Deliverables.

8.5.5.7.3. Modifying surveys and tools to capture HCBS population specific information and data.

8.5.5.8. Contractor shall work with the Department and CMA partners to identify, create, participate in, and administer training necessary to provide seamless care coordination to shared Members.

8.5.5.9. Contractor shall work with the Department and CMA partners to report on and improve Member and caregiver experience in a format agreed upon by Contractor and Department.

8.5.6. Dual Eligible Special Needs Plans (D-SNPs)

8.5.6.1. Contractor shall collaborate with the Department and D-SNPs to improve the effective management and coordination of care for dually-enrolled Medicare and Medicaid Members over the term of the contract. The Department may revise contract requirements to conform with CMS guidance and regulations regarding D- SNPs, with which Contractor shall comply.

8.5.6.1.1. Contractor shall enter into documented agreements in accordance with requirements of 8.5.2. with each D-SNP in Contractor's assigned service area and any other D-SNP known to be serving Contractor's Members to ensure dually-enrolled Medicare and Members receive the most effective and comprehensive care.

8.5.6.2. Contractor shall collaborate with D-SNPs responsible for shared Members to conduct a comprehensive analysis of the benefit structure between D-SNP plans and the Medicaid benefits to ensure a thorough comprehension and application in coordinating Medicaid services for Members and jointly educate providers that serve dually-enrolled Members to improve Provider utilization of available benefits and Member outcomes.

8.5.6.3. Contractor shall actively collaborate with the D-SNP to complement and support the D-SNP's Care Coordination activities, particularly as the activities relate to Medicaid services not covered by the D-SNP.

8.5.6.4. Contractor shall identify D-SNP enrolled Members on ADT feeds and have processes to identify and coordinate appropriate Care Coordination services to optimize a Member's outcomes and reduce duplication of efforts.

8.5.6.4.1. Contractor shall establish a robust system to receive and manage Skilled Nursing Facility (SNF) and inpatient admission information provided by the D- SNP within two Business Days of a Member's admission.

8.5.6.4.2. Contractor shall continuously monitor SNF and inpatient admissions to ensure that timely and appropriate responses to these admissions are made, including, at minimum, necessary Care Coordination activities that contribute to the successful inpatient outcomes.

8.5.6.5. Contractor shall have documented policies and procedures developed with the D-SNPs responsible for shared Members for timely collaboration on shared Members to address the Care Coordination needs of Members that are stratified in Tier 3 Care Management, aiming

to improve health outcomes for these Members. Contractor shall report these procedures as part of the Policy and Procedures Deliverable.

8.5.6.6. Contractor shall track and ensure Care Coordination engagement rates and appropriate types of Care Coordination are being provided to the D-SNP Members. Contractor shall utilize the data collected to improve care outcomes and Care Coordination efforts.

8.5.7. Child Welfare/Foster Care

8.5.7.1. Contractor shall work with each county child welfare office in Contractor's service area in order to improve the timely notification of children and youth Members involved in the child welfare system who require Care Coordination support, including but not limited to Members in foster care and those who have recently (within one year) emancipated from foster care.

8.5.7.2. Contractor shall address the complex health risks for children and youth in foster care by monitoring and coordinating a child or youth's utilization of consistent, preventative care in medical, behavioral, vision, and oral health.

8.5.7.3. Contractor shall engage children and youth in the Child and Youth Medicaid System of Care as determined eligible in accordance with Section 11.

8.5.7.4. Contractor shall implement evidence-based and promising practices to support the transition of emancipated foster care youth (at least six months prior to emancipation and at least one year post emancipation) that complement the work of child welfare and other state programs supporting this population.

8.5.7.4.1. Contractor shall ensure that the care plan for each emancipated foster care youth is informed by an assessment of the young person's transition readiness.

8.5.7.4.2. Contractor shall offer transition education to young people preparing to emancipate, including but not limited to education about continuing prescribed medications, attending physical and Behavioral Health appointments, receiving preventative care, independent living skills, etc.

8.5.7.4.3. Contractor shall support the young person's engagement with existing programs serving youth transitioning out of foster care, including the John H. Chafee Foster Care Program for Successful Transition to Adulthood.

8.5.8. Justice-Involved Members

8.5.8.1. Contractor shall participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for Members involved in carceral settings.

8.5.8.2. Contractor shall partner with the Department and the Colorado Department of Corrections (CDOC), Division of Youth Services, Colorado Judicial Branch, and jails in Contractor's service area to identify and provide services to Medicaid- eligible individuals being released from carceral settings to enable the Medicaid-eligible individuals to transition successfully to the community.

8.5.8.3. Contractor shall receive and process a list from the CDOC containing information about incarcerated individuals who have recently been released or will be released in the near future.

8.5.8.3.1. Contractor shall process the lists to identify individuals who are assigned to Contractor or will be released to Contractor's service area and are likely to be assigned to Contractor.

8.5.8.4. Contractor shall provide services to Members assigned to or who are likely to be assigned to Contractor that include, but are not limited to:

8.5.8.4.1. Timely outreach and transitional support to assist a Member's successful transition to the community.

8.5.8.4.2. Activities prior to a Member's release in accordance with any federally approved waiver agreement or federal requirement, including but not limited to an assessment to identify needs the Member will have upon release.

8.5.8.4.3. Care transition support, which may include but is not limited to supporting continued access to all medications prescribed to the Member during and/or prior to incarceration, including but not limited to Medication Assisted Treatment.

8.5.8.4.4. Coordination of transitional support between CDOC, Division of Youth Services, jails, and other RAEs for Members who were likely to but ultimately were not assigned to Contractor.

8.5.8.5. Contractor shall connect Members deemed incompetent to proceed with appropriate restoration services whether or not the services are covered by Medicaid, in coordination with the Office of Civil and Forensic Mental Health.

8.5.9. Creative Solutions/Complex Solutions Expectations

8.5.9.1. Contractor shall lead and facilitate Complex Solutions meetings for adults and Creative Solutions meetings for children in accordance with Department policies.

8.5.9.2. Contractor shall ensure that Creative Solutions and Complex Solutions meetings include the Member's care team, the member's Case Management Agency, and Department staff in order to identify solutions for Members experiencing significant barriers to care, including but not limited to difficult placements.

8.5.9.3. Contractor shall use templates provided by the Department to refer, track, and monitor Members involved in Creative/Complex Solutions, including, at minimum, documenting the following information:

8.5.9.3.1. Contractor's demonstrated efforts and attempts to identify Member solutions prior to referring to Creative/Complex Solutions.

8.5.9.3.2. A plan to bridge support for Members between discharge from higher levels of care and waitlists for step-down services.

8.5.9.3.3. When solutions are unsuccessful, summarize the reasons and any missed opportunities and/or future plans to prevent similar outcomes.

8.5.9.3.4. **DELIVERABLE:** Creative/Complex Solutions Report

8.5.9.3.5. **DUE:** To be determined by the Department

8.6. Care Coordination Policy Guide

8.6.1. Contractor shall have documented policies and procedures for the delivery of Care Coordination in the service area in accordance with the Work.

8.6.1.1. Contractor's documented Care Coordination policies and procedures shall include at minimum, all of the following:

8.6.1.1.1. Differentiate the strategies used for children from those used for adults by each tier.

8.6.1.1.2. Include descriptions of the specific interventions that Contractor or its Network Providers, delegated or subcontracted entities will employ, the identified populations of focus, the criteria for deploying the interventions, and how Contractor will measure the effectiveness in alignment with Department guidelines.

8.6.1.1.2.1. Contractor shall specify how it will collaborate with Network Providers and subcontracted or delegated entities to provide Care Coordination activities the other parties are unable to offer to ensure every Member receives equal access to the full continuum of Care Coordination.

8.6.1.1.3. Describe specific strategies for identifying, engaging, and coordinating care for populations meeting Department criteria for Care Coordination as well as demographic populations historically subject to health inequities.

8.6.1.1.4. Document policies and procedures for care transitions as detailed in Section 8.4.

8.6.1.1.5. Document policies and procedures for system collaboration, including but not limited to collaboration with CBOs, D-SNPs, CMAs, BHASOs, the child welfare system, and justice-involved Members.

8.6.2. Contractor shall submit Care Coordination policies and procedures to the Department prior to the Operational Start Date and upon Department request.

8.6.2.1. **DELIVERABLE:** Care Coordination Policies/Procedures

8.6.2.2. **DUE:** June 1, 2025, with updates due upon Department request

8.7. Data, Systems, and Performance

8.7.1. Contractor shall provide Care Coordination tools, processes, and methods to Network Providers for their utilization.

8.7.2. Contractor shall ensure that clinical and claims data feeds, including but not limited to ADT data received from a Colorado Health Information Exchange, monthly claims data, CMA case manager data feeds, the Inpatient Hospital Transitions data feed, and the Nurse Advice Line Data feed, are actively used in providing Care Coordination for Members.

8.7.3. Contractor shall receive, process, and analyze clinical, claims, and other available data from the Department and Contractor and shall work collaboratively with the Department to stratify Contractor's population into the Care Coordination tiers, as well as identify trends, potentially avoidable costs, and impactable populations.

8.7.4. Contractor shall facilitate data sharing across all treating Providers, Subcontractors, and delegated entities, and ensure the completion of necessary consents and releases of information.

8.7.5. Contractor shall collect minimum data across all organizations and care coordinators to whom Contractor contractually delegates Care Coordination Member engagement in Care Coordination shall be defined as bi-directional communication where the Member response is more than the Member opting out of Care Coordination. Communication can occur in-person or through telecommunication including phone, text, email, video, or Member portal.

8.7.6. Contractor shall develop and maintain mechanisms to collect the Care Coordination engagement information from Subcontractors, delegated Care Coordination entities, and Network Providers performing Care Coordination as part of Contractor's established payment arrangement with Contractor's Subcontractors, delegated Care Coordination entities, and Network Providers performing Care Coordination.

8.7.6.1. Contractor shall be responsible for cleaning and collating the data for submission to the Department.

8.7.7. Contractor shall submit Care Coordination Engagement Data to the Department in a standardized format determined by the Department.

8.7.7.1. Contractor shall submit, at a minimum, all of the following Care Coordination engagement data:

8.7.7.1.1. Member identifier for Members who actively engaged in a Care Coordination intervention during the previous month.

8.7.7.1.2. Member's Care Coordination stratification tier based on Contractor's methodology.

8.7.7.1.3. Entity who provided the Care Coordination intervention.

8.7.7.1.4. Date of Care Coordination intervention.

8.7.7.1.5. Member identifier for Member's who opted out of Care Coordination.

8.7.7.1.6. Member has a documented comprehensive care plan: yes/no.

8.7.7.1.7. Contractor shall submit Care Coordination Engagement Data to the Department in a standardized format determined by the Department.

8.7.7.2. **DELIVERABLE:** Care Coordination Engagement Data

8.7.7.3. **DUE:** Quarterly, not later than October 15, January 15, April 15, and July 15

8.8. Care Coordination Outcome Metrics

8.8.1. Contractor's Care Coordination program shall be evaluated based on Contractor's performance on the following metrics:

8.8.1.1. Care Coordination outreach engagement rate: Contractor shall report the number of outreach attempts for Members in Contractor's Tier 3 Care Management.

8.8.1.2. Hospital All-cause Readmission rate based on NCQA methodology.

8.8.1.2.1. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed upon performance target that shall not be more than the previous three year average for the Hospital All-Cause Readmission rate for Members in Tier 3 Care Management.

8.8.1.3. Transitions of care from hospitals for physical health conditions (based on NCQA methodology): The percent of Members who received a follow-up service within 30 days after discharge during the previous quarter.

8.8.1.3.1. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed upon performance target for Members who have had an ED visit or inpatient (IP) admission that have been outreached or received a follow-up visit within 7 Business Days of the ED or IP encounter per year. Contractor shall not be held accountable for this Performance Standard prior to SFY 2026-27 or later as determined by the Department.

8.8.1.4. Transitions of care from Behavioral Health inpatient stay (based on HEDIS methodology): The percent of Members who received a follow-up service within seven days after discharge during the previous quarter.

8.8.1.5. Ambulatory Care: ED Visits based on NCQA methodology.

8.8.1.5.1. **PERFORMANCE STANDARD:** The Department and MCEs shall mutually agree upon a performance target and methodology for annual performance improvement for the ED Visit performance metric for Members eligible for Tier 2 Care Coordination and Tier 3 Care Management.

8.8.2. Contractor shall submit a Care Coordination Report to the Department in a format determined by the Department. The report shall include an overview of the Care Coordination activities for Members performed by Contractor, Network Providers and Partners, and Subcontractors.

8.8.2.1. **DELIVERABLE:** Care Coordination Report

8.8.2.2. **DUE:** Every six months, by August 15th and February 14th

9. PROVIDER SUPPORT PRACTICE TRANSFORMATION

9.1. Overview

9.1.1. Contractor shall serve as a central point of contact for Network Providers regarding Medicaid services and programs, Department Value Based Payment strategies and programs, regional resources, clinical tools, integrated care, and general administrative information.

9.1.2. Contractor shall serve as a vital support to the success and sustainability of primary care and the continuum of behavioral health throughout Contractor's service area by providing data, actionable analytics, education, and supplemental services and supports to make it easier for Network Providers to deliver care to Members and by reducing administrative burdens and barriers where possible.

9.1.2.1. Taking into consideration alignment with other RAE and Department efforts, Contractor shall identify and work to reduce administrative burdens and barriers for Network Providers where possible and engage the Department as necessary around statewide issues and challenges Network Providers face across the RAE regions.

9.1.3. Contractor shall use Contractor's Population Health Management Strategy defined in Section 7 to inform Contractor's Practice Support activities for Network Providers.

9.1.4. Contractor shall offer Network Providers the following types of support, described in further detail in the rest of this section:

9.1.4.1. Provider communications.

9.1.4.2. General information and administrative support.

9.1.4.3. Provider training.

9.1.4.4. Data systems and technology support.

9.1.4.5. Practice transformation, financial support, and reporting.

9.1.5. Contractor shall deliver an Annual Contracted Network Management Strategic Plan that includes, at minimum, all of the following information:

9.1.5.1. Contractor's Network Adequacy Plan

9.1.5.2. The types of information and administrative support, Provider trainings, and data and technology support Contractor shall offer and make available to Network Providers.

9.1.5.3. The practice support and practice transformation activities Contractor will implement to support successful Network Provider participation in Department efforts to integrate behavioral and physical health care delivery, to incorporate community health workers into the Medicaid delivery system, to implement Value-Based Payment models, and to achieve Department quality and cost savings metrics.

9.1.5.4. The practice transformation strategies Contractor will offer to help practices progress along CDOI's defined aligned core competencies for primary care alternative payment models as well as strategies to help practices engage with Contractor's efforts to implement Contractor's Population Management Strategy.

9.1.5.5. How Contractor is supporting Network Providers and the region with improving coordination throughout the Health Neighborhood and reducing costs. Details could include practice support, utilization of Department dashboards and data, performance data, and more.

9.1.5.6. Descriptions of Contractor's work, including successes and lessons learned, during the previous year.

9.1.5.7. Savings and engagement performance of each PCMP, for each delegated obligation or program.

9.1.5.8. Comparison between Contractor's engagement and savings versus delegated PCMP engagement and savings.

9.1.5.9. Reporting of barriers and burdens Network Providers face, the strategies Contractor pursued to help ease identified barriers and burdens, and identification of issues that may require Department and or State intervention.

9.1.5.10. Contractor shall submit the Annual Contracted Network Management Strategic Plan to the Department.

9.1.5.10.1. **DELIVERABLE:** Annual Contracted Network Management Strategic Plan

9.1.5.10.2. **DUE:** Annually, on or before August 1

9.1.5.10.3. Contractor shall submit a Practice Support and Transformation Report to the Department that provides updates on Contractor's implementation of Provider support

and practice transformation activities described in the Annual Contracted Network Management Strategic Plan. Contractor shall document, at a minimum, progress on milestones and outcome goals, notable barriers and burdens Network Providers are facing, and lessons learned.

9.1.5.10.4. **DELIVERABLE:** Practice Support and Transformation Report

9.1.5.10.5. **DUE:** Annually, by February 1

9.2. Provider Communication

9.2.1. Contractor shall have documented policies and procedures to confirm that Contractor's Provider communications adhere to the Department's brand standards.

9.2.2. Contractor shall maintain consistent communication, both proactive and responsive, with Network Providers and other partners, and promote communication among Providers.

9.2.3. Contractor shall maintain, staff, and publish the number for a toll-free telephone line and a general Provider relations email address, and a web-based form that Providers may contact regarding general information, administrative support, and complaints, including, but not limited to, contracting, credentialing, claims, and payment.

9.2.3.1. Contractor shall post their relevant Provider relations email address, phone number, and web-based form on their website.

9.2.3.2. During Business Hours, Contractor shall have processes and procedures to prevent more than five percent of phone calls being abandoned in any consecutive 30-day period. A call shall be considered abandoned if the caller hangs up after that caller has waited in the call queue for 180 seconds or longer.

9.2.3.3. Contractor shall have processes and procedures to ensure that the average length of time phone callers wait in the call queue before the call is answered shall be two minutes or less during each calendar month.

9.2.3.4. Contractor shall have no more than five phone calls during any consecutive five Business Days that experience a maximum delay of ten minutes or longer, and no calls shall exceed a maximum delay over 20 minutes.

9.2.3.4.1. **PERFORMANCE STANDARD:** 98% compliance with each Provider call line contact management requirement each month.

9.2.3.5. Contractor shall respond to all Provider inquiries within two Business Days.

9.2.3.6. Contractor shall have an automated response to their Provider relations email and/or web-based form that states the expected response time and provides a link to the Department Provider Escalation Form.

9.2.3.7. Contractor shall submit monthly response time data from its Provider telephone line, Provider relations email, and web-based form in the Call Line Statistics Report.

9.2.4. Contractor shall collaborate with the Department to respond to, and address complaints submitted to the Department through the Department Provider Escalation Request Form or other mechanisms.

9.2.4.1. Contractor shall outreach Providers who have submitted a complaint to the Department within two Business Days after the Department informing Contractor.

9.2.4.1.1. **PERFORMANCE STANDARD:** 90% of Providers who expressed a complaint to the Department are outreached by Contractor within two Business Days of the Department informing Contractor of the complaint. 98% of Providers who expressed a complaint to the Department are outreached by Contractor within five Business Days of the Department informing Contractor of the complaint.

9.2.5. Contractor shall establish a process for tracking and responding to and expeditiously resolving Provider complaints submitted to Contractor and the Department.

9.2.5.1. Contractor shall utilize a formal tracking mechanism that easily enables Providers to follow up with Contractor regarding a specific complaint submitted to Contractor.

9.2.5.2. For Provider issues that cannot be resolved within five Business Days, Contractor shall document a process for how Contractor is working to resolve the issue and provide a weekly update to the Department, either in writing or during a regularly scheduled meeting.

9.2.5.2.1. For inquiries that take longer than five Business Days to resolve, Contractor shall provide a specific name and contact information for a staff person that Provider will work with to resolve the issue. Contractor shall provide the staff member name and contact information via the method of communication the Provider used to contact Contractor.

9.2.5.2.2. **PERFORMANCE STANDARD:** 80% of Network Provider complaints submitted to the Department or Contractor shall be resolved by Contractor, as determined by the Department, within 20 Business Days after Contractor's receipt of Provider complaint.

9.2.5.3. Contractor shall collaborate with the Department on how to best communicate with and work with Network Providers who regularly submit multiple complaints, escalations, and communications, including determining when it may be appropriate to establish signed communications plans with a Network Provider establishing clear processes and expectations regarding communications.

9.2.6. Contractor shall assist any Provider who contacts Contractor, including Providers not in Contractor's service area who need assistance determining which Members are attributed to the Provider's practice.

9.2.6.1. The Department will provide data to Contractor on all Members for this purpose.

9.2.7. Contractor shall use a variety of communication methods, including, at minimum, email lists and newsletters to communicate with Network Providers and Subcontractors and inform them of relevant Medicaid information and changes to any of Contractor's or the Department's policies and programs.

9.2.8. Contractor shall have a defined process to monitor the effectiveness of communication with Network Providers and Subcontractors, and to address communication deficiencies or crisis situations, including how Contractor shall increase staff, contact hours, or other steps Contractor shall take if existing communication methods for Network Providers are insufficient.

9.2.9. Contractor shall have a single point of contact to support the Behavioral Health Independent Provider Network (IPN).

9.2.9.1. The single point of contact for the IPN shall have authority to factor in the IPN's concerns and considerations into Contractor policies and procedures.

9.2.9.2. The single point of contact for the IPN shall attend workgroups, forums, and meetings in which the IPN is the focus.

9.3. General Information and Administrative Support

9.3.1. Contractor shall have processes and procedures to provide informational support to Network Providers, while not duplicating existing materials.

9.3.2. Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for all of the following topics, at a minimum:

9.3.2.1. General information about Medicaid, the ACC, and Contractor's role and purpose, including details about Contractor's Care Coordination program.

9.3.2.2. The Department's process for handling appeals of physical health adverse benefit determinations and Contractor's process for handling appeals of physical health adverse benefit determinations.

9.3.2.3. Available Member resources, including the Member provider directory.

9.3.2.4. Clinical resources, such as screening tools, clinical guidelines, evidence-based disease prevention and management resources, practice improvement activities, templates, trainings, and any other resources Contractor has compiled.

9.3.2.5. Community-based resources and inventories for health-related social needs, such as childcare, food assistance, services supporting elders, housing assistance, utility assistance, and other non-medical supports.

9.3.2.6. The Department's Value-Based Payment strategy and models available to Network Providers.

9.3.3. Contractor shall distribute information and provide technical assistance to complement the Department's efforts to help Network Providers understand the following Colorado Medicaid program information:

9.3.3.1. Medicaid eligibility.

9.3.3.2. Medicaid covered benefits.

9.3.3.3. State Plan services.

9.3.3.4. EPSDT.

9.3.3.5. HCBS waiver services.

9.3.3.6. Capitated Behavioral Health Benefit .

9.3.3.7. Claims and billing procedures.

9.3.3.8. Prescriber tool opioid risk mitigation module and affordability module.

9.3.3.9. Out-of-state medical care as described in 10 CCR 2505-10 8.013.

9.3.3.10. Out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

9.3.4. Contractor shall inform Network Providers of key Department contractors and the roles, and responsibilities, including:

9.3.4.1. Colorado Medicaid's fiscal agent.

9.3.4.2. Electronic Data Warehouse (EDW).

9.3.4.3. Enrollment broker.

9.3.4.4. Pharmacy Benefit Management System.

9.3.4.5. Provider Performance and Quality Measurement (PPQM).

9.3.4.6. Utilization Management.

9.3.4.7. Oral Health contractor.

9.3.4.8. NEMT administrators.

9.3.4.9. Case Management Agencies.

9.3.4.10. Nurse Advice Line.

9.3.4.11. Crisis Services System.

9.3.5. Contractor shall act as a liaison between the Department and the Department's other contractors, partners, and Providers.

9.3.6. Contractor shall outreach to and educate specialists and other Providers regarding the ACC, the role of Contractor, and the supports Contractor will offer to Providers in Contractor's region.

9.3.7. Contractor shall assist Providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:

9.3.7.1. Provider enrollment.

9.3.7.2. Member eligibility and coverage policies.

9.3.7.3. Service authorization and referral.

9.3.7.4. Member and PCMP assignment and attribution.

9.3.7.5. PCMP designation.

9.3.7.6. EPSDT benefits.

9.3.7.7. Prescriber tool opioid risk mitigation module and affordability module.

9.3.7.8. eConsult tool and benefit.

9.3.8. Contractor shall use, and recommend to Network Providers, medical management, clinical and operational tools to promote optimal health outcomes and to control costs for Members. The suite of tools and resources should offer a continuum of support for Network Providers and the broader Health Neighborhood.

9.4. Provider Training

9.4.1. Contractor shall, at a minimum, develop trainings and host forums for ongoing training regarding the ACC and the services Contractor offers.

9.4.2. Contractor shall promote participation of Network Providers in state, local, and Contractor specific training programs.

9.4.3. Contractor shall have processes and procedures to make available trainings and updates on the following topics to Network Providers minimum once every six months:

9.4.3.1. Colorado Medicaid eligibility and application processes.

9.4.3.2. Medicaid benefits.

9.4.3.3. Access to Care standards.

9.4.3.4. EPSDT.

9.4.3.5. Contractor's Population Management Strategic Plan, including Care Coordination models.

9.4.3.6. ASAM criteria.

9.4.3.7. Use and proper submission of BHA supported data collection and other tools, including the most current BHA data collection products that track SUD, crisis and mental health, encounter data, the referrals and bed tracking tool, and the Central Registry Medication Assisted Treatment tool.

9.4.3.8. Cultural and disability competency.

9.4.3.9. Language assistance education to better serve Members who speak languages other than English.

9.4.3.10. Federal and state nondiscrimination statutes and regulations.

9.4.3.11. Member rights, Grievances, and Appeals.

9.4.3.12. Quality improvement initiatives, including those to address population health.

9.4.3.13. Principles of recovery and psychiatric rehabilitation.

9.4.3.14. Trauma-informed care.

9.4.3.15. The Department Value-Based Payment methodologies, at minimum, specifically during the time leading up to and during Contractor and Network Provider's contract execution and regular amendment process.

9.4.3.16. NEMT.

9.4.3.17. Fraud, Waste, and Abuse.

9.4.4. Contractor shall develop training or educational materials on how hospital staff can request assistance from Contractor in discharging Members to care in the community.

9.4.4.1. On a quarterly basis, Contractor shall share Contractor's trainings or educational materials on how hospital staff can request discharge assistance from Contractor to all hospital care discharge team members with whom Contractor works.

9.4.5. Contractor shall maintain a record of training activities it offers, including Provider attendance at "live" trainings and utilization of any web-based trainings, and submit to the Department upon request.

9.5. EPSDT Universal Screenings

9.5.1. Contractor shall assist the Department in ensuring EPSDT eligible populations receive regularly scheduled examinations and evaluations of their general physical and mental health, growth, development, and nutritional status, in accordance with 42 CFR Part 441 Subpart B.

9.5.2. In the support of this goal, Contractor shall:

9.5.2.1. Implement policies, training, and practice transformation activities for Network Providers that improve Colorado's compliance with "AAP Bright Futures" recommendations for preventive pediatric healthcare, also known as the "periodicity schedule," in primary care settings.

9.5.2.2. Implement policies, training, and care integration strategies into diverse child and youth settings including, but not limited to schools, crisis settings, and other community-based organizations.

9.5.2.3. Implement policies and procedures to promote the utilization of developmental, social, behavioral, and mental health screeners among all children and youth Members.

9.5.3. Contractor shall work with the Department and other Managed Care Entities to create an EPSDT Uniform Accountability Strategy describing best practices for all Managed Care Entities to follow to ensure state compliance with EPSDT.

9.5.3.1. In developing an EPSDT Uniform Accountability Strategy, Contractor shall leverage Department provided resources that include, but are not limited to:

9.5.3.1.1. National experts.

9.5.3.1.2. National landscape and best practices.

9.5.3.1.3. Data and systems support to execute on plan.

9.5.3.2. Contractor shall participate in creating an EPSDT Uniform Accountability Strategy that shall include, but is not limited to:

9.5.3.2.1. Training and outreach plan on improving performance, including how Managed Care Entities will educate and provide practice transformation support to Providers on using the screening tools developed according to 27-62-103, C.R.S., which required the state, in partnership with the community, to select developmentally appropriate and culturally competent statewide Behavioral Health standardized screening tools for primary care Providers.

9.5.3.2.2. Plans for engaging Providers and places of service across the community (e.g. schools, crisis Providers) to promote the early identification of child and youth conditions where families are most often seeking services.

9.5.3.2.3. Recommendations for identifying positive screens and tracking referrals to Treatment; and

9.5.3.2.4. Contractor reporting and partnership commitment to improve EPSDT screening and referral to treatment compliance.

9.5.3.3. Contractor shall work with the Department and other MCEs to complete the EPSDT Uniform Accountability Strategy within six months after the Effective Date.

9.5.3.4. Contractor shall implement the Department-approved EPSDT Uniform Accountability Strategy within 90 days of being directed in writing by the Department.

9.5.4. Contractor shall have policies and procedures to support and educate Network Providers on the utilization of evidence-based screening tools, including screening tools designed to identify needs of children and youth with other systems involvement or comorbidities.

9.5.4.1. Contractor shall ensure that its network includes Providers who are trained on the use of the different approved screening tools to align with reliability and validity.

9.5.5. Contractor shall support and train Providers to deliver active monitoring and follow up or refer a child or youth to a Behavioral Health Provider following a positive Behavioral Health screen as indicated by level of severity under AAP Bright Futures.

9.5.6. Contractor shall have documented policies and procedures to educate and support Providers with referring children and youth with any screen that indicates a significant level of severity to an appropriate Provider for follow up care within 30 days of identified need. This includes but is not limited to positive screens, for the following:

9.5.6.1. Behavioral Health.

9.5.6.2. Development.

9.5.6.3. Physical Health.

9.5.6.4. Vision.

9.5.6.5. Dental.

9.5.6.6. Early intervention.

9.5.7. Contractor shall work with the Department to design, implement, and utilize any and all state data systems being used to identify children and youth with a screen that indicates the presence of a condition (i.e. a positive screens) and that Contractor is able to track child and youth referrals to appropriate specialty care.

9.6. Data Systems and Technology Support

9.6.1. Contractor shall have expertise to support providers in implementing and utilizing health information technology (HIT) systems and data. Contractor shall keep up to date with changes in HIT in order to best support providers.

9.6.2. Contractor shall educate and inform Network Providers about the Department's and Contractor's data reports and systems available to the providers and the practical uses of the available reports and tools.

9.6.3. Contractor shall make available technical assistance and training for Network Providers on how to use the following state-supported HIT systems in complement to existing Department efforts:

9.6.3.1. Contractor's Care Coordination Tool.

9.6.3.2. The EDW and PPQM Systems.

9.6.3.3. interChange.

9.6.3.4. BHA's data collection products that track SUD, crisis, and mental health encounter data.

9.6.3.5. PEAK website and PEAKHealth mobile app.

9.6.3.6. Regional health information exchange.

9.6.3.7. Electronic consultation and referral tools.

9.6.3.8. Prescriber tool.

9.6.3.9. SHIE.

9.6.3.10. BHA's referral and bed tracking tool and Medication Assisted Treatment Central Registry.

9.6.3.11. Provider Portal.

9.6.3.12. Department provided Value-Based Payment related portal and dashboards.

9.6.4. Contractor shall participate in and encourage Network Provider participation in learning collaboratives or other regional or statewide meetings on State and Department efforts to advance HIT systems and data aggregators in Colorado.

9.6.4.1. Contractor shall identify opportunities to complement and support state- and Department-hosted meetings and facilitate gatherings in Contractor's service area upon the Department's request and as Contractor deems appropriate.

9.6.5. Contractor shall offer the following supports to Network Providers on managing and utilizing data:

9.6.5.1. Provide practice-level data, reports, and/or assist Network Providers in utilizing Department provided data and reports.

9.6.5.2. Train Network Providers on how to utilize data to:

9.6.5.2.1. Succeed in the Department administered Value-Based Payment models.

9.6.5.2.2. Improve care for Complex Members.

9.6.5.2.3. Improve Transitions of Care.

9.6.5.2.4. Improve care for Members with Department identified health conditions.

9.6.5.2.5. Implement wellness and prevention strategies.

9.6.5.2.6. Reduce inappropriate and inefficient care.

9.6.5.2.7. Understand how their practice is performing on KPIs and other health outcome measures.

9.6.5.2.8. Identify Members who require additional services.

9.6.5.3. Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the Network Providers, both behavioral health claims from Contractor's internal system and physical health claims data from the Department.

9.6.5.3.1. Contractor shall establish and implement a process for Network Providers to request raw claims data extracts from Contractor.

9.6.6. State Supported HIT Systems

9.6.6.1. Contractor shall provide technical and other support to Network Providers to increase the adoption and utilization rates of all state-supported HIT systems.

9.6.6.2. Contractor shall keep track of which Network Providers do not have specific tool functionality for state-supported HIT systems within their electronic health records (EHRs) and periodically share this list with the Department.

9.6.6.3. eConsult

9.6.6.3.1. Contractor shall encourage PCMPs to adopt and utilize the Department's eConsult platform, or other Department approved platforms, to expand the accessibility of specialist care to Members and enhance the PCMPs' capacity to provide comprehensive care to Members.

9.6.6.3.2. Contractor shall provide targeted outreach and workflow support to PCMPs who care for Members with limited access to transportation and/or who live in rural and frontier areas to increase adoption of eConsult and to try and provide as much care as possible through the PCMP, reducing the need for Members to travel for services that can be coordinated and managed effectively by the PCMP.

9.6.6.3.3. Contractor shall promote eConsult tools to specialty care Providers in Contractor's service area to increase the participation of specialty care Providers in eConsults and to improve specialty care Provider workflows, experience of care, and Member no-show rates.

9.6.6.3.4. Contractor shall coordinate with the Department and the Department's eConsult vendor on eConsult, sharing lessons learned and reporting challenges faced by Network Providers and Health Neighborhood Providers in the adoption and utilization of eConsult.

9.6.6.3.5. **PERFORMANCE STANDARD:** Contractor shall achieve a two percentage point annual increase in adoption of the eConsult benefit by PCMPs using any Department-approved platform. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

9.6.6.3.6. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed upon percent of PCMPs who have adopted a Department-approved platform who also submitted an eConsult within the past 12 months. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

9.6.6.4. SHIE

9.6.6.4.1. Contractor shall disseminate information and provide technical assistance to Network Providers and the Health Neighborhood about the SHIE and promote the adoption of the SHIE and associated interoperable technologies for referring Members to health improvement programs and community resources for health-related social needs.

9.6.6.4.2. Contractor shall support Network Providers with incorporating utilization of the SHIE within practice workflows.

9.6.6.4.3. Contractor shall establish processes with Network Providers regarding when and how Contractor can assist, follow-up, and/or wraparound additional services for Members referred for programs through the SHIE.

9.6.6.4.4. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed upon improvement target for training and supporting Network Providers and Health Neighborhood entities in accessing and using the SHIE. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

9.6.6.5. Health Information Exchange (HIE)

9.6.6.5.1.1. Contractor shall incentivize Network Providers to be connected to the state's health information exchange (HIE) for exchanging clinical alerts, clinical quality measures data, and the bidirectional exchange of patient health information, including clinical care documents (CCDs) and Health Level Seven (HL7) data standards for admit and discharge data. All electronic submissions to the HIE must include all patient data, including behavioral health data and data covered by 42 CFR Part 2 if applicable. Contractor shall promote the use of Office of the National Coordinator for Health Information Technology (ONC) Interoperability Standards for PCMP EHR systems, to improve data exchange. These standards are at https://www.healthit.gov/policy-researchers- implementers/interoperability.

9.6.6.5.1.2. Contractor shall assist Network Providers in accessing all available resources, such as the Clinical Health Information Technical Advisor (CHITA) support, to increase transfer of clinical documents (CCDs) to support accurate reporting of CMS Core Measures.

9.6.6.5.1.3. Contractor shall identify and address gaps in information sharing or data quality among Network Providers, Contractor, and the Department.

9.7. Practice Transformation

9.7.1. Contractor shall offer practice transformation support to Network Providers interested in improving performance and participating in Value-Based Payment models.

9.7.2. Contractor shall make available to Network Providers individualized practice coaching on topics that include, but are not limited to, the following

9.7.2.1. Team-based care and leveraging all staff to provide services within their full scope of practice.

9.7.2.2. Improving business practices and workflow.

9.7.2.3. Continuous quality improvement coaching and education on the delivery of evidence-based medicine.

9.7.2.4. Financial planning for quality-based payments and non-traditional payment arrangements, such as prospective payments.

9.7.2.5. Coordinating and integrating primary care and behavioral health services.

9.7.2.6. Incorporating lay health workers, such as promotoras, peers, community health workers, and patient navigators in accordance with the implementation of § 25.5- 5-334, C.R.S.

9.7.2.7. Addressing Members' health-related social needs.

9.7.2.8. Implementing health programming to advance Contractor's Population Management Strategic Plan.

9.7.2.9. Activities designed to improve Member health and experience of care.

9.7.3. Contractor shall partner with any interested Network Provider to identify the existing strengths of the Network Provider and to design and implement practice transformation strategies that build on these strengths and support the Network Provider in achieving the Network Provider's individualized practice goals.

9.7.4. Contractor shall participate as a full member of the Colorado Health Extension System to effectively leverage and align Contractor's activities statewide practice transformation programs and initiatives available and reduce administrative burden and duplication of activities for Network Providers.

9.7.5. Contractor shall incentivize PCMP participation in practice transformation activities utilizing the PCMP Payment Program and pay-for-performance payments.

9.7.6. Contractor shall collaborate with the Department and stakeholders around the design and implementation of a PCMP Assessment Tool that inventories, evaluates, and captures information about a PCMP's unique capabilities within CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models.

9.7.6.1. Contractor shall assess Contractor's PCMPs at minimum, one time annually using the Department-approved standardized PCMP Assessment Tool. Contractor shall partner with the Department and PCMPs to continually improve the PCMP Practice Assessment Tool and reduce the administrative burden on PCMPs.

9.7.6.2. Contractor shall collaborate with the Department on developing a reporting template that communicates the continuum of competencies for Contractor's network of PCMPs, including the provision of integrated physical and behavioral health, and how the network competencies of PCMPs are advancing over time.

9.7.6.2.1. Contractor shall identify PCMPs who provide integrated physical and behavioral health care based on the PCMP Practice Assessment Tool and submit information in a manner and format approved by the Department to add this information to the interChange Provider file.

9.7.6.3. **PERFORMANCE STANDARD**: Contractor shall show the PCMP Network's year-over-year progression along CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models based on results of the PCMP Practice Assessment Tool.

9.7.7. 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 as defined in the research literature, and supporting the identification and analysis of service overutilization.

9.7.8. Contractor shall partner with interested Network Providers to establish and document feasible, measurable transformation goals that best fit a practice's overall operational strategy. Based on the practice's goals, Contractor shall develop a practice transformation plan to:

9.7.8.1. Connect Network Providers to practice transformation resources that are readily available in the region, such as those available through the Colorado Health Extension System.

9.7.8.2. Educate Network Providers about the methods, principles, best practices, and benefits of practice transformation.

9.7.8.3. Provide technical assistance, tools, and resources as appropriate.

9.7.8.4. Measure the Network Provider's progress against the identified transformation goals.

9.7.9. Contractor shall use existing practice transformation and support organizations in the service area and the state and coordinate with existing efforts, when appropriate, to reduce duplication of efforts and overburdening practices.

9.7.10. Contractor's practice transformation activities that should be available ongoing to any interested Network Provider shall include, but not be limited to:

9.7.10.1. Sharing Contractor-developed chronic condition and health improvement programs.

9.7.10.2. Sharing actionable data with Network Providers to improve their ability to prioritize Care Coordination and Member engagement.

9.7.10.3. Working with Network Providers to meet regional access, quality (CMS Core Measures), and other outcome and equity goals, including the Department's health equity plan goals.

9.7.10.4. Supporting Network Providers with either implementing new or improving existing integrated physical and behavioral health care activities.

9.7.10.5. Establishing processes for improved coordination with and referrals to specialty care Providers.

9.7.10.6. Working with Network Providers to develop and/or utilize Care Coordination and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary ED use and total cost of care.

9.7.10.7. Assisting Network Providers on integrating new tools and best practices into their workflows, such as utilizing eConsults, the Prescriber Tool OpiSafe and Real-Time Benefits Inquiry (RTBI) modules, SHIE, emerging cost and quality indicators, and other innovations that evolve through Phase III of the ACC.

9.7.10.8. Helping Network Providers utilize and leverage state investments in rural health, such as the Department's implementation of Senate Bills 22-200 and 23-298.

9.7.11. Value-Based Payment Practice Support Activities

9.7.11.1. Contractor shall provide practice support that enables Network Providers to adopt and be successful in Value-Based Payment models through improving quality of care and health outcomes and transitioning Providers financial model.

9.7.11.2. Contractor shall support Network Providers participation in the Department's and Contractor's Value-Based Payment models for both Behavioral health and primary care.

9.7.11.3. Contractor shall support the success and sustainability of Network Providers in transitioning away from historical Fee-For-Service models in accordance with the Department's Value-Based Payment strategy and any Department rules and regulations.

9.7.11.3.1. Contractor shall serve as an essential resource to help Network Providers maximize payment by improving Network Providers' performance on health outcome metrics.

9.7.11.3.2. Contractor shall support Network Providers with understanding how their payments can vary based on performance on health outcome goals, and then provide practice

transformation activities to enable the interested Network Providers to achieve the performance goals.

9.7.11.3.3. Contractor shall have sufficient knowledge to effectively support PCMPs with different types of funding, such as Federally Qualified Health Centers, Rural Health Centers, or Comprehensive Providers, or will partner with the appropriate organizations to sufficiently support these types of PCMPs.

9.7.11.3.4. Contractor's ability to earn performance payments and shared savings are dependent upon Contractor's successful support of Network Providers in achieving Value-Based Payment goals and metrics.

9.7.11.4. Contractor's Value-Based Payment practice support activities shall include, but not be limited to:

9.7.11.4.1. Educating Network Providers about all Value-Based Payments available to the provider.

9.7.11.4.2. Provision of actionable data to support achieving CMS core metric performance at Department designated benchmarks.

9.7.11.4.3. Clinical and process strategies to successfully reach quality targets and earn Value-Based Payments.

9.7.11.4.4. Individualized support on strategies to promote financial sustainability, including:

9.7.11.4.4.1. Explanations of and considerations for practice transition to prospective payments, quality-based payments, per-member-per-months (PMPMs), shared savings, and other non- traditional revenue streams.

9.7.11.4.4.2. Budgeting and accounting considerations for payment transition.

9.7.11.4.4.3. Best practices for reconciliation of prospective payments to utilization.

9.7.11.5. Contractor shall participate in Value-Based Payment initiatives, meetings, trainings, and strategic planning lead by the Department, BHA, and CDOI.

9.7.11.6. Contractor shall designate staff and communication methods, such as a dedicated phone line, email address, or web-based form for the exclusive purpose of providing support to Network Providers and responding to Network Provider questions regarding the Department's primary care Value-Based Payment models, as well as Contractor's and the Department's Value-Based Payment models for behavioral health.

9.7.11.7. Contractor shall serve as an essential resource to help PCMPs understand their Department generated payment rates in the Department's Value-Based Payment programs.

9.7.11.7.1. Contractor shall be the primary point of contact for PCMPs to explain therates and the rate calculation methodology. Contractor shall serve as the primary point of questions. For questions which Contractor cannot answer Contractor shall refer those questions to the Department for further clarification.

9.7.11.8. Based on the needs of the service area and the existing practice transformation resources available, Contractor shall offer trainings, learning collaboratives, and/or other resources to support practices in participating in the Department's Value- Based Payment models.

9.7.11.8.1. Contractor shall leverage Department tools and resources for trainings to reduce Provider confusion and promote consistency around the models.

9.8. Financial Support

9.8.1. Contractor shall promote the reduction in administrative burden on Network Providers by aligning Contractor's practice support initiatives to Department-approved national and state Value-Based Payment models, including, but not limited to:

9.8.1.1. Colorado Division of Insurance's Primary Care Alternative Payment rules and regulations.

9.8.1.2. The Department's implementation of the Center for Medicare & Medicaid Innovations (CMMI's) Making Care Primary model.

9.8.2. PCMP Payment Program

9.8.2.1. Contractor shall design and implement Payment for PCMP Network Providers to complement the Department's Primary Care Alternative Payment Models and to improve PCMPs' ability to deliver high-quality health outcomes for Members and maximize payment.

9.8.2.1.1. Contractor's PCMP Payment Program shall be designed to achieve, at minimum, all of the following:

9.8.2.1.1.1. Increase equitable Member access to adult and pediatric primary care.

9.8.2.1.1.2. Incentivize PCMPs to participate in practice transformation activities and progress along the continuum of advanced primary care in alignment with CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models, while minimizing administrative burden on the PCMP.

9.8.2.1.1.3. Incentivize PCMPs to deliver more intensive Care Coordination interventions for higher acuity Members while reporting Care Coordination data elements outlined in Section 8.

9.8.2.1.1.4. Incentivize PCMP adoption and utilization of Department and state supported health technologies, such as the Prescriber Tool and eConsult benefit.

9.8.2.1.2. Contractor shall utilize the Department-approved PCMP Practice Assessment Tool to assess PCMP capabilities and determine the tier for which a PCMP qualifies.

9.8.2.1.2.1. Contractor shall have PCMPs complete the PCMP Practice Assessment Tool and attest to their capabilities.

9.8.2.1.2.2. Contractor shall annually audit at minimum 10% of PCMPs self assessments and adjust a PCMP's tier as appropriate.

9.8.2.1.2.3. If the Contractor's payment to PCMPs is based in part or in whole on the PCMPs Practice Assessment Tool score, Contractor shall not recoup PCMP payments distributed to a PCMP prior to the Contractor's audit of a PCMP's payment tier.

9.8.2.1.2.4. Contractor's determination of a PCMP's tier shall be considered final.

9.8.2.2. Integrated care payment

9.8.2.2.1. Contractor shall design a payment strategy to complement the Department's efforts to promote and increase the integration of behavioral health services in primary care settings.

9.8.2.2.2. Contractor shall use the PCMP Practice Assessment Tool to identify where PCMPs are along the continuum of integrated care.

9.8.2.2.2.1. Contractor shall submit a report to the Department identifying PCMPs who meet any of the criteria as an integrated care PCMP.

9.8.2.2.2.2. Contractor shall provide reimbursement to PCMPs who meet minimum Department-specified criteria as an integrated care PCMP.

9.8.2.3. Care Coordination payment

9.8.2.3.1. Contractor may distribute funding to PCMPs who are capable of and are committed to providing advanced levels of Care Coordination beyond the basic Medical Home standards of Care Coordination.

9.8.2.3.2. Contractor shall require PCMPs that receive a Care Coordination payment to have mechanisms to routinely report to the RAE information on individual Member Care Coordination activities.

9.8.2.3.3. Contractor shall report contracted Care Coordination relationships with PCMPs in the Care Coordination Roles Report.

9.8.2.4. Contractor-determined payment

9.8.2.4.1. Contractor may design and implement innovative payment strategies designed to further achievement of Department goals and priorities. For example, Contractor may offer financial support for activities such as sustaining established quality standards, providing disability accessible equipment and access, employing practitioners who speak languages other than English, and reporting clinical quality metrics.

9.8.2.4.2. Contractor's unique payment strategies shall not duplicate or conflict with the Department pay-for-performance program.

9.8.2.5. Contractor shall submit to the Department for review and approval a detailed reporting of the payment strategy to be established with Network Providers.

9.8.2.5.1. The MCO Network Provider Payment Report shall be designed to complement the Annual Contracted Network Management Strategic Plan.

9.8.2.5.1.1. **DELIVERABLE:** MCO Network Provider Payment Report

9.8.2.5.1.2. **DUE:** Annually, by August 1

9.8.3. Financial, Programmatic, and Resource Support for Rural Providers

9.8.3.1. Contractor shall design and implement strategies to enhance financial and technical support of Network Providers and other Providers in rural communities to complement the Department's implementation of Senate Bill 22-200 and Senate Bill 23-298 and other work to support the sustainability of rural and CEAC health services and to better manage care for Members living in rural and CEAC areas.

9.8.3.2. Contractor shall provide shared resources, condition management programming, supporting communication tools, and population health analytics at no cost to small independent Providers and rural Providers including RHCs, to the extent a Provider doesn't have these resources and is willing to partner with Contractor.

9.8.3.3. Contractor may fund investments in needed and shared infrastructure and services across rural hospitals and rural clinics that may include Care Coordination tools and models, software, technology upgrades, and assistance connecting to, maintaining, and utilizing state HIT systems, particularly the state HIEs.

9.8.4. Provider Performance Statements

9.8.4.1. Contractor shall create and send to any Network Providers that they have a value-based payment contract with a quarterly Provider Performance Statement that offer detailed information about practice-level performance and Contractor's and Department's value-based payments distributed to the Network Provider.

9.8.4.2. Contractor's Provider Performance Statements shall combine information generated by Contractor, the Department, and the Department's Value-Based Payment vendor.

9.8.4.3. Contractor's Provider Performance Statements shall include, but is not limited to, all of the following information:

9.8.4.3.1. Quality metric performance results calculated by the Department or its designated vendor.

9.8.4.3.2. Quality metric performance results calculated by Contractor.

9.8.4.3.3. Utilization data from the Department or Contractor that impacts the Network Provider's metric performance or payment.

9.8.4.3.4. Description of whether Provider's performance met criteria for payment for each specific quality metric.

9.8.4.3.5. Clear identification of payments distributed, including identification of any payments for achieving specific metric performance and advanced primary care tier.

9.8.4.3.6. Member level data identifying how the Network Provider could intervene to achieve a specific performance metric and earn pay for performance payments. This could consist of a link or notification of data available through the PPQM or other available Department or Contractor resource.

9.8.4.3.7. Recommendations of how Contractor can support the Network Provider to improve performance in the future.

9.8.4.4. Contractor shall support the dissemination of the Provider Performance Statement as timely as possible to enable Network Providers to take action before the performance period ends.

9.8.4.5. Contractor shall educate Network Providers on how to read the Provider Performance Statement, how to track and reconcile payments, how to understand the financial implications, and how to develop a plan for improvement.

9.8.5. Provider Satisfaction Survey

9.8.5.1. Contractor shall implement a Network Provider satisfaction survey to assess the effectiveness and usefulness of Contractor's provider support, practice transformation, and provider relations.

9.8.5.2. Contractor shall develop a Network Provider Satisfaction Survey Plan.

9.8.5.2.1. Contractor's Network Provider Satisfaction Survey Plan shall include the process by which Contractor shall assess Network Provider satisfaction including how it will make the survey or tool available to Network Providers, how it will receive completed responses, how it will choose which Network Providers are included, and how it will maximize the response rate.

9.8.5.2.2. Contractor shall submit the Network Provider Satisfaction Survey Plan to the Department for review and approval.

9.8.5.2.2.1. **DELIVERABLE:** Network Provider Satisfaction Survey Plan

9.8.5.2.2.2. **DUE:** 30 days prior to the Operational Start Date

9.8.5.2.3. Contractor shall review its Network Provider Satisfaction Survey Plan annually with the Department to determine if any modifications are necessary, that the Network Provider satisfaction survey is accurately measuring the Network Provider's experience, and that the responses received are timely, in sufficient numbers, and applicable. Contractor shall make all required edits to the Network Provider Satisfaction Survey Plan based on this review or as directed by the Department.

9.8.5.2.3.1. **DELIVERABLE:** Updated Network Provider Satisfaction Survey Plan

9.8.5.2.3.2. **DUE:** Annually, by July 1

9.8.5.2.4. Contractor shall administer all Network Provider satisfaction surveys in accordance with Contractor's most recently approved Network Provider Satisfaction Survey Plan.

9.8.5.3. Contractor's Network Provider Satisfaction Survey shall measure Network Provider satisfaction with Contractor's Work in categories that include, but are not limited to, the following:

9.8.5.3.1. Customer service, including responsiveness, promptness, and ease to reach a satisfactory resolution for both digital and telephonic interactions with customer service representatives.

9.8.5.3.2. Effectiveness, accuracy, and applicability of Network Provider education training and materials.

9.8.5.3.3. Effectiveness and applicability of practice transformation efforts.

9.8.5.3.4. Effectiveness and usability of Contractor provided tools, data, and analytics.

9.8.5.3.5. PAR processing and determinations.

9.8.5.3.6. Claims processing.

9.8.5.4. Contractor shall submit its Network Provider satisfaction survey data to the Department upon request for the Department's evaluation of results.

9.8.5.5. Contractor shall submit its evaluation of Network Provider satisfaction survey data and results to the Department. Contractor shall identify opportunities for improvements and describe Contractor's plans to address Network Provider needs through training, system updates, automation, etc. that are likely to improve Network Provider experience and result in better Member outcomes.

9.8.5.5.1. **DELIVERABLE:** Network Provider Satisfaction Survey Evaluation

9.8.5.5.2. **DUE:** Annually, on October 1

10. CAPITATED PHYSICAL HEALTH BENEFIT

10.1. Contractor shall administer and deliver the Capitated Physical Health Benefit.

10.1.1. As the Administrator of the Capitated Physical Health Benefit, Contractor shall, at minimum, ensure delivery of all of the following:

10.1.1.1. Receive a Capitated Payment for each Member and ensure the Capitated Payments support Members achieving physical health and wellbeing.

10.1.1.2. Employ strategic health care management practices described throughout the Contract in administering the benefit, create financial incentives to drive quality care and have strong Member experience protections.

10.1.1.3. Administer the Capitated Physical Health Benefit in a manner that is fully integrated with the entirety of the Work.

10.1.2. Contractor shall increase access to physical health services for all Medicaid Members, by ensuring at minimum, all of the following:

10.1.2.1. Take full responsibility for providing, arranging for, or otherwise taking responsibility for the provision of all Medically Necessary covered physical health services

10.1.2.2. Contractor shall commit to administering the Capitated Physical Health Benefit in line with the following principles:

10.1.2.2.1. 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.

10.1.2.2.2. Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

10.1.2.2.3. Least Restrictive Environment: The provision of community-based supports and services that enable Members with serious mental illness and other disabilities to live in the community to the greatest extent possible and as appropriate.

10.1.2.2.4. 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.

10.1.2.2.5. Prevention and Early Intervention: Broad community-wide efforts to reduce the impact of physical health conditions on Members and communities.

10.1.2.2.6. Integrated Care: Commitment to implementing integrated care approaches in line with Department initiatives.

10.1.2.2.7. Evidence-based: Treatment is provided in accordance with the established evidence-based practices and emerging promising practices.

10.1.2.2.8. Member and Family Centered Care: Services and supports are provided in the best interest of the Member to ensure that the needs of the Member and family are being addressed. Systems, services, and supports are based, when appropriate, on the strengths and needs of the entire family or community.

10.1.2.2.9. Health Equity and cultural responsiveness: Contractor shall consider factors related to health equity to ensure Members have access to culturally responsive, disability competent, and meaningful care.

10.1.3. Contractor shall develop policies and procedures on how Contractor shall respond to requests from Network Providers for interpreter services.

10.1.4. Contractor shall track Network Providers who do not offer Covered Services because the Provider objects to the service on moral or religious grounds in order for Contractor to ensure Members understand Members' ability to access alternative services and can make Members' own fully informed choices.

10.2. Covered Services

10.2.1. Health Coverage

10.2.1.1. Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit M. Contractor shall provide Care Coordination, Utilization Management and Medical Management for Members to promote the appropriate and cost-effective utilization of Covered Services in multiple community-based venues to increase accessibility and improve outcomes. Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. Treatment sites may include but are not limited to schools, homeless shelters, skilled nursing and assisted living residences, and Members' homes.

10.2.1.2. Contractor may cover services or settings that are in lieu of State Plan services if the following criteria are met:

10.2.1.2.1. The Department deems the alternative service or setting as a Medically Necessary appropriate substitute for the Covered Service or setting.

10.2.1.2.2. The Department deems the alternative service or setting as a cost-effective substitute for the Covered Service or setting.

10.2.1.2.3. Contractor does not require the Member to use the alternative service or setting.

10.2.1.2.4. Alternative services and settings are outlined in Exhibit M.

10.2.1.2.5. The alternative services and settings are offered to Members during the enrollment process.

10.2.1.3. 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.

10.2.1.4. 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.

10.2.1.5. Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service if Contractor objects to the service on moral or religious grounds.

10.2.1.6. Any cost sharing imposed on Members is in accordance with Medicaid FFS requirements at 42 CFR 447.50 through 42 CFR 447.82

10.2.2. Covered Services Through Network Providers

10.2.2.1. Covered Services shall be made available in the service area only through Network Providers or non-Network Providers authorized by Contractor. A Network Provider is any Physician, Hospital, or other healthcare professional or facility that has entered into a professional service agreement with Contractor to provide clinical services to Contractor's Members.

10.2.2.2. Except for Emergency Services, Post Stabilization Services, and Urgently Needed Services, Contractor shall have no liability or obligation to pay for any service or benefit sought or received by any Member from any non-Network Provider unless:

10.2.2.2.1. Special arrangements or referrals are made by a Network Provider or Contractor, as specified in the Member handbook.

10.2.3. Coverage of Specific Services and Responsibilities

10.2.3.1. Emergency Services

10.2.3.1.1. Emergency Services include, at minimum, all of the following:

10.2.3.1.1.1. Furnished by a provider that is qualified to administer these services according to 42 CFR 438.

10.2.3.1.1.2. Needed to evaluate or stabilize an Emergency Medical Condition.

10.2.3.1.1.3. Contractor shall be responsible for coverage and payment of Emergency Services and Post-Stabilization Care Services as specified in 42 CFR § 438.114(b) and 42 CFR § 422.113(c). Contractor shall, at a minimum:

10.2.3.1.1.3.1. Cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with Contractor.

10.2.3.1.1.3.2. Pay non-contracted Provider for Emergency Services no more than the amount that would have been paid if the service had been provided under the State's FFS Medicaid program.

10.2.3.1.1.3.3. Shall not deny payment for treatment obtained under either of the following circumstances:

10.2.3.1.1.3.3.1. 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.

10.2.3.1.1.3.3.2. A representative of Contractor instructs the Member to seek Emergency Services.

10.2.3.1.1.3.4. Not refuse to cover Emergency Services based on the emergency room provider, hospital or fiscal agent not notifying Contractor of the Member's screening and treatment within ten calendar days after the Member's presentation for Emergency Services.

10.2.3.1.1.3.5. 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.

10.2.3.1.1.3.6. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor for coverage and payment.

10.2.3.1.1.3.7. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Provider Network that are pre-approved by Contractor.

10.2.3.1.1.3.8. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's network that are not pre- approved by Contractor, but are administered to maintain, improve, or resolve the Member's stabilized condition if any of the following are true:

10.2.3.1.1.3.8.1. Contractor does not respond to a request for pre-approval within one hour of receiving the request.

10.2.3.1.1.3.8.2. Contractor cannot be contacted.

10.2.3.1.1.3.8.3. Contractor and the treating provider cannot reach an agreement concerning the Member's care and a plan Provider is not available for consultation. In this situation, Contractor shall give the treating provider the opportunity to consult with a Network Provider and the treating provider may continue with care of the Member until a Network Provider is reached or one of the criteria in 42 CFR § 422.113(c)(3) is met.

10.2.3.1.1.3.8.4. Contractor shall limit charges to Members for Post-Stabilization Care Services to an amount no greater than what Contractor would charge the if the Member had obtained the services through Contractor.

10.2.3.1.1.4. Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved shall end when any of the following occur:

10.2.3.1.1.4.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Member's care.

10.2.3.1.1.4.2. A Network Provider assumes responsibility for the Member's care through transfer.

10.2.3.1.1.4.3. Contractor and the treating provider reach an agreement concerning the Member's care.

10.2.3.1.1.4.4. The Member is discharged.

10.2.3.1.1.5. Contractor shall ensure that Members within the service area shall have access to Emergency Services on a 24 hour per day, seven day per week basis.

10.2.3.2. Emergency Ambulance Transportation

10.2.3.2.1. Contractor shall make reasonable efforts to ensure that Members within the service area shall have access to emergency ambulance transportation on a 24 hour per day, seven day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.

10.2.3.3. Verification of Medical Necessity for Emergency Services

10.2.3.3.1. Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services. Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions. Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

10.2.3.4. Post-Stabilization Care Services

10.2.3.4.1. Contractor shall provide coverage for Post-stabilization Care Services in compliance with 42 CFR §§ 438.114(e) and 422.113(c).

10.2.3.5. Coverage of Prescription Drugs

10.2.3.5.1. Contractor shall not allow the use of spread pricing, as defined by CMS, by Contractor's Pharmacy Benefit Management System.

10.2.3.5.2. Medicare Prescription Drug, Improvement, and Modernization Act (MMA).

10.2.3.5.2.1. Contractor shall not provide drugs described in Medicare Part D to Members eligible for both Medicare and Medicaid.

10.2.3.5.2.2. Contractor shall comply with all federal and state statutes and regulations regarding prescription drug benefits described in Medicare Part D for Members eligible for both Medicare and Medicaid.

10.2.3.5.2.3. Contractor shall cover excluded Part D drugs as defined in 42 U.S.C. §1395w-101, et seq., for Members 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 Members.

10.2.3.5.3. Contractor shall provide coverage for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Contractor's internal prior authorization criteria shall not apply to prescription drugs carved out of this Contract. Such covered drugs must be prescribed and dispensed within Contractor's parameters for pharmaceuticals, and as follows:

10.2.3.5.3.1. Contractor shall establish a drug formulary, for all Medically Necessary covered drugs with its own prior authorization criteria, provided Contractor includes each

therapeutic drug category in the Medicaid program. Contractor shall ensure that the formulary requires the following:

10.2.3.5.3.1.1. Information in electronic or paper form about which generic and name brand medications are covered, as well as which tier each medication is on.

10.2.3.5.3.1.2. The formulary drug list on Contractor's website in a machine-readable file and format as specified by the Secretary.

10.2.3.5.3.2. Contractor shall develop and maintain a prior authorization program to provide covered drugs for any Medically Necessary conditions unmet by Contractor's formulary product. Contractor shall ensure that the program includes the following criteria:

10.2.3.5.3.2.1. Provision of a telephonic or telecommunication response within 24 hours of a request for prior authorization; and

10.2.3.5.3.2.2. Prescription of at least a 72 hour supply of outpatient covered drugs in an Emergency situation, with the exception of drugs referred to in § 42 USC 1396r-8(d)(2) of the Act. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

10.2.3.5.4. If a Member requests a brand name drug for a prescription that is included on Contractor's drug formulary in generic form, the Member may receive the brand name drug by paying the cost difference between the generic and brand name drug. In this event, the Member must sign the prescription stating that the member will pay the difference in price, between the generic and the brand name drug, to the pharmacy.

10.2.4. Outpatient Drug Coverage & Drug Utilization

10.2.4.1. Contractor shall develop and maintain a Drug Utilization Review (DUR) program that complies with the requirements described in §§ 1927(g) and 1927(d)(5)(A) of the Act, §1004 of the Support for Patient and Communities Act, and 42 CFR part 456, subpart K. Contractor's DUR program shall perform the following functions:

10.2.4.1.1. Prospective drug review, including:

10.2.4.1.1.1. A prospective safety edit regarding:

10.2.4.1.1.1.1. Days' supply for patients not currently receiving opioid therapy for initial prescription fills.

10.2.4.1.1.1.2. Early refills, for subsequent prescription fills.

10.2.4.1.1.1.3. Therapeutically duplicative initial and subsequent opioid prescription fills.

10.2.4.1.1.1.4. Quantity of prescription dispensed for initial and subsequent prescription fills.

10.2.4.1.1.1.5. The maximum daily morphine equivalent for treatment of pain.

10.2.4.1.1.2. Retrospective drug use review, including:

10.2.4.1.1.2.1. 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 Department.

10.2.4.1.1.2.2. An automated claims review process that indicates fills of opioids in excess of limitations identified by the Department.

10.2.4.1.1.2.3. An automated claims review process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

10.2.4.1.1.2.4. 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.

10.2.4.1.1.2.5. Processes to identify potential fraud or abuse of controlled substances by beneficiaries, health care Providers, and pharmacies.

10.2.4.1.1.2.6. Establish and operate a DUR Board.

10.2.4.1.1.2.7. An educational program.

10.2.4.1.2. Contractor shall exclude encounters for Covered Drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization data reports submitted to the Department.

10.2.4.1.3. 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. 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.

10.2.4.1.3.1. **DELIVERABLE:** DUR Program Activities Report

10.2.4.1.3.2. **DUE:** Within 45 days, after receiving a written request from the Department.

10.2.4.1.4. Contractor shall cover all outpatient drugs as defined in 42 USC § 1396r-8 and § 1927(k)(2) of the Act based on Medical Necessity.

10.2.4.1.5. Contractor shall either cover only those outpatient drugs that are eligible for rebate, or that are purchased through the 340B Drug Pricing Program pursuant to 42 USC 1396r-8 and § 1927(j)(1) of the Act.

10.2.4.1.6. Contractor shall not cover drugs purchased through the federal 340B Pricing Program when dispensed by 340B contract pharmacies pursuant to § 1927(a)(5) of the Act.

10.2.4.1.7. Contractor shall not cover non-rebateable drugs purchased outside of the Federal 340B Drug Pricing Program, pursuant to §§ 1927(a)(1) and (b)(1)(A) of the Act.

10.2.4.1.8. Contractor shall provide a formulary for covered outpatient drugs that is no more restrictive than the Department's formulary for coverage, pursuant to 42 CFR § 438.210.

10.2.4.1.9. Contractor shall report the following drug utilization data and information necessary for the Department to bill manufacturers for rebates no later than 45 days after the end of each quarterly rebate period:

10.2.4.1.9.1. Total number of units of each dosage form, strength, and package size by National Drug Code of all outpatient drugs covered and dispensed by Contractor.

10.2.5. Inpatient Hospital Services

10.2.5.1. Contractor shall be responsible for inpatient hospital stays based on the Principal Diagnosis that requires inpatient care.

10.2.5.1.1. Contractor shall be financially responsible for when the Member's Primary or Principal Diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric procedures.

10.2.5.1.2. Contractor shall not be financially responsible for inpatient services when the Member's Principal Diagnosis is psychiatric in nature, even when the psychiatric hospitalization includes some medical conditions or procedures to treat a secondary medical diagnosis

10.2.5.1.3. Contractor shall not be responsible for the hospital stay when the Principal Diagnosis is for substance abuse rehabilitation.

10.2.5.2. Coverage for Emergency Services

10.2.5.2.1. Contractor shall be responsible for Emergency Services when the Member's Principal Diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures.

10.2.5.3. **PERFORMANCE STANDARD:** Contractor shall ensure that 95% of Members discharged from a hospital have been outreached within 72 hours after the Member's discharge.

10.2.5.4. 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.

10.2.5.5. Contractor's responsibility for the Covered Services of outpatient Hospital Services is based on the diagnosis and the billing procedures of the Hospital.

10.2.5.5.1. For any procedure billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) format, Contractor shall be responsible for all Covered Services associated with a Member's outpatient hospital services Covered Services, including all psychiatric, medical and facility Covered Services, if:

10.2.5.5.1.1. The procedure is billed on a UB-92/ANSI 837I claim form, and

10.2.5.5.1.2. The Principal Diagnosis is a medical diagnosis.

10.2.5.5.2. For any procedure billed in a HCFA-1500/ANSI 837P, Health Care Claim Professional Format, Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

10.2.5.5.2.1. The procedure is billed on a HCFA-1500/ANSI 837P claim form, and 10.2.5.5.2.2.

10.2.5.5.2.2. The Covered Services are not listed as a required Capitated Behavioral Health Benefit Covered Service as defined in 10 C.C.R. 2505-10, §8.212.4. A. Diagnoses and procedures listed in Exhibit K.

10.2.5.6. Wrap Around (Fee For Service) Benefits

10.2.5.6.1. Contractor shall communicate to its Network Providers and Members information about Medicaid wrap around benefits, which are not Covered Services under this Contract but are available to Members under Medicaid fee for service (FFS).

10.2.5.6.2. Contractor shall instruct its Network Providers on how to refer a Member for such services. Contractor shall advise Network Providers of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) support services that are available through other entities. 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.

10.2.5.6.3. Contractor shall inform its home health services Providers and Members that home health services after 60 consecutive days are not Covered Services but are available to Members under FFS and require prior authorization. If home health services after 60 consecutive days are anticipated, Contractor shall ensure that, at least 30 days prior to the 60th day of home health services, its home health services Providers coordinate prior authorization with the CMA for adult Members and with the Medicaid fiscal agent for children.

10.2.5.6.4. Contractor shall inform its Network Providers of the services provided by the MCOs.

10.2.6. Coverage of Abortions

10.2.6.1. Contractor shall cover abortions in the following situations, in accordance with 42 CFR § 441.202 and the Consolidated Appropriations Act of 2008:

10.2.6.1.1. When the pregnancy is the result of an act of rape or incest.

10.2.6.1.2. 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.

10.3. Exclusions

10.3.1. Acupuncture.

10.3.2. Air ambulance services when a Member could be safely transported by ground ambulance or by means other than ambulance.

10.3.3. Ambulatory surgical procedures not listed on the state approved list.

10.3.4. Ambulance services when a Member could be safely transported by means other than ambulance.

10.3.5. Audiology and Speech Pathology: With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids are not covered under this Contract but may be provided to children under the age of 21 through the Health Care Program for Children with Special Needs. Simple articulation or academic difficulties that are not medical or surgical in origin are also excluded.

10.3.6. Autopsy charges.

10.3.7. Biofeedback, stress management, behavioral testing and training, and counseling for sexual dysfunction.

10.3.8. Capitated Behavioral Health Benefit services as described in Exhibit B.

10.3.9. Chiropractic services unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

10.3.10. 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.

10.3.11. Counseling for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.

10.3.12. Dental services:

10.3.12.1. Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.

10.3.12.2. 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 Contractor to relate to a dental condition.

10.3.13. 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 vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities.

10.3.14. Experimental or investigational services or pharmaceuticals.

10.3.14.1. 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 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:

10.3.14.1.1. The treatment, procedure, drug or device must have final approval from the Food and Drug Administration (FDA), if applicable.

10.3.14.1.2. 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.

10.3.14.1.3. The treatment, procedure, drug or device must improve or maintain the net health outcome.

10.3.14.1.4. The treatment, procedure, drug or device must be as beneficial as any established alternative; and

10.3.14.1.5. The improvements in health outcomes must be attainable outside the investigational settings.

10.3.14.1.6. Additionally, the treatment, procedure, drug or device must be Medically Necessary and not excluded by any other Contract exclusion.

10.3.15. Government-sponsored care:

10.3.15.1. Items and services provided by federal programs, such as a Veteran's Hospital.

10.3.15.2. Services provided in facilities that serve a specific population, such as prisoners.

10.3.15.3. Care for conditions that federal, state, or local laws require to be treated in a public facility.

10.3.15.4. 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.

10.3.16. 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.

10.3.17. FQHC Services: Inpatient hospital stays are not covered under FQHC Services but may be a benefit under Inpatient Hospital Care.

10.3.18. 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.

10.3.19. 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 Exhibit M but may be provided to children under the age of 21 as a wraparound benefit. Simple articulation or academic difficulties that are not medical or surgical in origin are not covered under this Contract.

10.3.20. High colonics.

10.3.21. Holistic or homeopathic care including drugs and ecological or environmental medicine.

10.3.22. Home delivery: Services associated with non-emergent home delivery, unless prior authorized by Contractor, are excluded.

10.3.23. 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 Exhibit M.

10.3.23.1. Long Term Home as defined by 10 CCR 2505-10, § 8.520.K.3.a is excluded.

10.3.23.2. Home Health Services provided by a person who ordinarily resides in the Member's home or is an immediate family member are not covered.

10.3.24. Hospice services. Members 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. Members may request disenrollment.

10.3.25. Hypnosis.

10.3.26. Immunizations related to foreign travel.

10.3.27. Imaging (Radiology or X-ray) Services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

10.3.28. 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.

10.3.29. Inpatient hospital excluded services include:

10.3.29.1. Psychiatric/psychological care included and covered as part of the RAE Capitated Behavioral Health Benefit.

10.3.29.2. Discharge medications and experimental drugs.

10.3.29.3. Inpatient hospital services defined as experimental by the Medicare program.

10.3.29.4. 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.

10.3.30. Institutional care when provided for the primary purpose of controlling or changing Member's environment, or if custodial care, domiciliary care, convalescent care (other than extended care) respite care, rest cures or hospice care.

10.3.31. Isometric exercise.

10.3.32. Expenses for medical reports, including presentation and preparation.

10.3.33. Laboratory services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

10.3.34. Long Term Home Health as defined at 10 CCR 2505-10, § 8.520 is excluded.

10.3.35. 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 K 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 K.

10.3.36. 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.

10.3.37. Nurse Home Visitor Program - Home visiting program for first time mothers by Registered Nurses, with sites approved by and contracted with CDHS.

10.3.38. 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.

10.3.39. Physical examinations of the following nature are excluded:

10.3.39.1. 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.

10.3.39.2. 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.

10.3.40. 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.

10.3.41. Private Duty Nursing (PDN). Private duty nursing services are a wrap around benefit.

10.3.42. Psychiatric/psychological care as follows:

10.3.42.1. Milieu therapy.

10.3.42.2. Play therapy.

10.3.42.3. Day care.

10.3.42.4. Electroshock treatment rehabilitation.

10.3.42.5. Night care.

10.3.42.6. Family therapy.

10.3.42.7. Biofeedback.

10.3.43. Reversal of surgically performed sterilization or subsequent re-sterilization.

10.3.44. Skilled Nursing Facility Services are a Wrap Around Benefit.

10.3.45. Substance or alcohol abuse, inpatient or residential rehabilitation.

10.3.46. Surrogate Mother Services or supplies received in connection with a Member acting as or utilizing the services of a surrogate mother.

10.3.47. Transportation, non-emergent, to medical appointments.

10.3.48. Travel, whether or not recommended or prescribed by a Physician or other medical practitioner.

10.3.49. 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.

10.3.50. 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:

10.3.50.1. 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.

10.3.50.2. Comprehensive dental assessment, care, and treatment for children.

10.3.50.3. Adult Dental services consist of diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic treatment and oral surgery.

10.3.50.4. Doula services.

10.3.50.5. 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.

10.3.50.6. 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.

10.3.50.7. HCBS Services include case management (for Model 200 children); home modification, electronic monitoring, personal care, and non-medical transportation.

10.3.50.8. Hospice services, however, Member may continue to get care not related to the terminal illness from the HMO but will be disenrolled if requested.

10.3.50.9. Hospital back up level of care as set forth in 10 CCR 2505-10, § 8.470.

10.3.50.10. Inpatient substance abuse rehabilitation treatment for individuals aged 20 and under, DRG 772, as set forth in 10 CCR 2505-10, § 8.300.4.5.

10.3.50.11. Intestinal Transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department & HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai.

10.3.50.12. Non-emergency transportation to medical appointments for Covered Services only, through the Member's county of residence.

10.3.50.13. Pediatric Behavioral Therapies.

10.3.50.14. Personal care benefit for children.

10.3.50.15. Private Duty Nursing (PDN), nursing services only.

10.3.50.16. Skilled Nursing Facility Services (skilled nursing and rehabilitation services) if Member meets level of care certification. Wrap-around skilled nursing facility services include those services set forth at 10 CCR 2505-10, § 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.

10.4. Service Limits

10.4.1. Contractor shall provide covered services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

10.4.2. Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

10.4.3. Contractor shall ensure that services supporting beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

10.4.4. Contractor shall not arbitrarily deny or reduce the amount, scope or duration of a required service solely because of the diagnosis, type of illness or condition.

10.4.5. Contractor may place appropriate limits on a service as follows:

10.4.5.1. On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

10.4.5.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose and services supporting Members with ongoing or chronic conditions are authorized in a manner that reflects the Member's ongoing needs.

10.4.5.2.1. Contractor may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or SUD benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQLT in the same benefit classification of the Members medical/surgical benefits.

10.4.6. Contractor shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

10.4.7. Contractor shall inform Members, or their families/designated representative, by email, phone, or mail of the approved timeframe for select authorized services, such as residential treatment and inpatient hospitalizations, so that Members, or their representatives, are aware of how long the services have been authorized for and therefore may request a continuation of and/or additional services if needed. Contractor shall record and document its notification of Members and families.

10.4.8. Contractor shall establish clear and specific criteria for discharging Members from treatment.

10.4.8.1. Contractor shall include this criteria in Member materials and information.

10.4.8.2. Contractor shall note individualized criteria for discharge agreed upon by Member and Provider in the Member's health care record and modified, by agreement, as necessary.

10.4.9. Contractor shall not be liable for any Covered Services provided prior to the date a Member is enrolled under this Contract or after the date of disenrollment.

10.4.9.1. Contractor shall not hold a Member liable for Covered Services:

10.4.9.1.1. Provided to the Member, for which the Department does not pay Contractor

10.4.9.1.2. 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

10.4.9.1.3. Furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor provided the services directly

10.4.10. Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

10.5. Service Planning, Coordination and Care Transitions

10.5.1. Based on the Member's needs and level of care required, Contractor shall ensure they have procedures for the following:

10.5.1.1. Intake and Assessment: Contractor shall ensure that each Member receives an individual intake and assessment appropriate for the level of care needed.

10.5.1.2. Service Planning: Contractor shall have a service planning system that uses the information gathered in the Member's intake and assessment to produce such a treatment or service plan or care plan in a timely manner.

10.5.1.3. Transitions of Care: Contractor shall provide continuity of care for Members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems.

10.5.1.4. Continued Services to Members: Contractor shall comply with the state's transition of care policy to ensure the continued access to services during a transition from one RAE/MCO to another RAE/MCO as required in 42 CFR § 438.62

10.5.2. Contractor shall not prohibit or restrict a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:

10.5.2.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

10.5.2.2. Any information the Member needs to decide among all relevant treatment options.

10.5.2.3. The risks, benefits, and consequences of treatment or non-treatment.

10.5.3. Contractor shall cooperate with federal evaluators and make any data available for the federal evaluation as is required under 42 CFR § 431.420(f) to support federal evaluation.

10.6. Utilization Management

10.6.1. Contractor shall facilitate seamless access to and actively manage the utilization of covered physical health services.

10.6.2. Contractor shall provide Covered Services, described in Section 10.4, in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

10.6.3. Contractor shall not arbitrarily deny or reduce the amount, scope, or duration of a required service solely because of the diagnosis, type of illness, or condition.

10.6.4. Contractor may place appropriate limits on a service as follows:

10.6.4.1. On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

10.6.4.1.1. Contractor shall determine Medical Necessity under EPSDT based on an individualized clinical review of a Member's medical status and in consideration that the requested treatment can correct or ameliorate a diagnosed health condition.

10.6.5. For Utilization Management (UM), provided the services furnished can reasonably be expected to achieve their purpose.

10.6.5.1. Contractor shall not apply any financial requirement or treatment limitation to mental health SUD 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.

10.6.5.2. For Members also enrolled in a physical health MCO, Contractor may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or SUD benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQLT in the same benefit classification of the Members medical/surgical benefits.

10.6.6. Contractor shall inform Members, or their families/designated representative(s), 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 families/designated representative(s), are aware of how long the services have been authorized for and therefore may request a continuation of and/or additional services if needed. Contractor shall record and document the Contractor's effort to notify Members and families.

10.6.7. Contractor shall develop and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR §§ 438.905 and 438.910, that includes, at a minimum, all of the following:

10.6.7.1. Utilization Management Program guidelines that consider the needs of Members.

10.6.7.2. Utilization Management Program and procedures designed and implemented in accordance with standards adopted by national accreditation organizations.

10.6.7.3. Periodic review and updates to utilization management guidelines as appropriate.

10.6.7.4. Description of the Utilization Management Program structure and assignment of responsibility for utilization management activities to appropriate individuals.

10.6.7.5. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

10.6.7.6. Identification of the type of personnel responsible for each level of Utilization Management decision-making.

10.6.7.7. Development and implementation of standards for the individual denying a service authorization request or authorizing a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease or by an individual who has documented a consultation with a health care professional with clinical expertise in treating the Member's condition or disease.

10.6.7.7.1. Individuals making Utilization Management decisions for children and youth eligible for the Medicaid System of Care or for admission to a PRTF or QRTP must be specially trained in EPSDT, Colorado's child and youth family System of Care guiding

principles, the Medicaid System of Care, Enhanced Standardized Assessment, and the CANS in order to facilitate the child and family-centered model.

10.6.7.8. 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.

10.6.7.9. Development and implementation of standards for Utilization Management personnel to consult with the ordering Provider prior to denial or limitation of requested/provided services.

10.6.7.10. Development and implementation of standards to ensure that services supporting beneficiaries with ongoing or chronic health conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports.

10.6.7.11. Clear and specific criteria for discharging Members from treatment.

10.6.7.11.1. Contractor shall include criteria in Member materials and information.

10.6.7.11.2. Contractor shall note individualized criteria for discharge agreed upon by Member and Provider in the Member's health care record and modified, by agreement, as necessary.

10.6.7.12. Policies and procedures for the use and periodic review of written clinical decision- making criteria based on clinical evidence.

10.6.8. Contractor's Utilization Management process shall in no way impede timely access to services.

10.6.9. Contractor shall establish clear procedures for Provider and Members to easily access the utilization management decision-making criteria upon request.

10.6.10. Contractor shall disseminate practice guidelines to all affected Providers and, upon request, Members and potential Members in compliance with 42 CFR § 438.236(c).

10.6.11. Contractor shall provide education and ongoing guidance to Members and Provider about its Utilization Management Program and protocols.

10.6.12. Contractor shall submit written documentation to the Department of any proposed significant changes to Contractor's Utilization Management Program and Procedures at least 30 days in advance of the proposed change going into effect.

10.6.12.1. **DELIVERABLE:** Notice of Proposed Utilization Management Change

10.6.12.2. **DUE:** 30 days in advance of the effective date of proposed change

10.6.13. Contractor shall communicate any changes to clinical review criteria and Contractor's Utilization Management Program and Procedures to Network Provider at least 30 days in advance of the changes taking effect.

10.7. PAR Requirements

10.7.1. Contractor shall not require prior authorization for outpatient psychotherapy services.

10.7.2. Contractor shall make determinations regarding prior authorization requests as expeditiously as possible to ensure compliance with the following standards as well as the Notice of Adverse Benefit Determination requirements described in Section 4. These requirements include the following:

10.7.2.1. Standard Authorization: As expeditiously as the Member's health condition requires, but no longer than seven calendar days following Contractor's receipt of the request for service.

10.7.2.1.1. Contractor may extend the seven day service authorization notice timeframe for up to 14 additional calendar days if the Member or the Provider requests an extension or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

10.7.2.1.2. If Contractor extends the seven day service authorization notice timeframe, Contractor must issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

10.7.2.1.3. **PERFORMANCE STANDARD:** 95% of standard PARs will be determined within seven calendar days following Contractor's receipt of the request for service.

10.7.2.2. Expedited Authorization: For cases in which a Provider, or Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or their ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than 72 hours after Contractor's receipt of the request for service.

10.7.2.2.1. Contractor may extend the 72 hours expedited service authorization decision time period by up to 14 days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

10.7.3. Contractor shall make all reasonable efforts to collect all missing, inadequate, or incomplete information of PARs in order to make determinations within the established timeframes.

10.7.3.1. Contractor shall keep administrative denials of PARs for missing, inadequate, or incomplete information to a minimum.

10.7.3.2. Contractor shall Monitor trends and shall have strategies and processes to intervene with a Provider that has an overall PAR denial rate of 10% or higher.

10.7.4. Peer to Peer Consultation

10.7.4.1. Contractor shall provide upon request Peer-to-Peer consultations that are defined as a process for the Member's ordering or rendering Provider to discuss a denial determination of an authorization with Member's physician. This review may also include the submission of additional clinical information for review.

10.7.4.2. Contractor shall conduct a Peer-to-Peer consultation for any Network Provider who is dissatisfied with Contractor's decision on any type of review and who has requested the peer-to-peer consultation after a denial or partial denial decision.

10.7.4.3. Contractor shall offer a Peer-to-Peer consultation to any Provider regardless of the PAR timeline.

10.7.4.4. Contractor shall review any additional clinical information during the peer-to-peer consultation, if submitted within the first five days following a denial decision

10.7.5. Notification of Denied Services and Alternative Services

10.7.5.1. If Contractor determines that the Member does not meet standards of Medical Necessity for Physical or Covered health services, Contractor shall inform the Member about alternative services and/or level of care that are recommended instead of the requested services and how other appropriate services may be obtained, pursuant to federal Medicaid managed care rules. Contractor shall coordinate within the Medicaid Provider system and the Health Neighborhood to refer the Member to the appropriate Provider, such as CMAs.

10.7.6. Contractor shall not be liable for any Covered Services provided prior to the date a Member is assigned to Contractor under this Contract or after the date of a Member's disenrollment.

10.7.7. Contractor shall not hold a Member liable for Covered Services:

10.7.7.1. Provided to the Member, for which the Department does not pay Contractor.

10.7.7.2. 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.

10.7.7.3. Furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor provided the services directly.

10.7.8. Contractor shall program and design a Utilization Management tracking system to meet data submission guidelines established by the Department.

10.7.8.1. Contractor shall submit Utilization Management Data to the Department or its contractor in a format determined by the Department.

10.7.8.1.1. **DELIVERABLE:** Utilization Management Data

10.7.8.1.2. **DUE:** Monthly, no later than 15 calendar days following the month for which the data covers

10.7.9. Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

10.7.10. 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.

10.7.10.1. .

10.7.11. In compliance with § 25.5-5-422, C.R.S., Contractor shall not:

10.7.11.1. Impose any prior authorization requirements on any prescription medication approved by the Food and Drug Administration (FDA) for the treatment of substance use disorders.

10.7.11.2. 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.

10.7.11.3. 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.

10.7.12. Contractor shall use the Department's established clinical coverage criteria and/or coverage standards for determinations of coverage of Specialty Drugs. When no Department coverage

criteria and/or coverage standards exists, Contractor shall make the determination in consultation with the Department, based on medical necessity and clinical evidence for use.

10.7.13. 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.

10.7.14. 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.

10.7.15. Contractor shall provide education and ongoing guidance to Members and Providers about its utilization management program and protocols.

10.8. Parity Compliance

10.8.1. Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

10.8.1.1. To meet the requirements of 42 CFR § 440.395, Contractor shall cover, in addition to services covered under the state plan, any behavioral health services necessary for compliance with the requirements for Parity in mental health and substance use disorder benefits in 42 CFR § 438 (k). Identification of services will be contingent upon work done by parity contractor's analysis.

10.8.2. Contractor may not impose NQTLs for mental health or SUD benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

10.8.2.1. Contractor's pre-authorization requirements shall comply with the requirements for parity in mental health and SUD benefits as described in 42 CFR § 440.395(b)(4).

10.8.2.2. 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:

10.8.2.3. Contractor shall provide all documentation necessary for determination of Contractor's compliance with Federal parity requirements. Contractor shall provide this documentation upon request for the Department's annual report as required by § 25.5-5-421, C.R.S.

10.8.2.3.1. **DELIVERABLE:** Parity Report Documentation

10.8.2.3.2. **DUE:** Within 21 days of the Department documentation request

10.9. Payments

10.9.1. Contractor shall reimburse practitioners for the provision of Covered Services within Contractor's established Utilization Management policies and agreed upon payment arrangements.

10.9.2. Unless otherwise stated in the Work, Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

10.10. FQHC And RHC Encounter Reimbursement

10.10.1. Contractor shall reimburse the FQHC or RHC by at least the encounter rate in accordance with 10 CCR 2505-10 § 8.700.6 and the Medicaid State Plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 § 8.700.3 for allowable costs identified in 10 CCR 2505-10 § 8.700.5. The Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

10.10.2. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505- 10 § 8.700.6C.

10.10.3. The Department shall notify Contractor of changes to the FQHC and RHC rates and rules.

10.10.4. 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), 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.

10.10.5. If multiple services are provided by an FQHC or RHC within one visit, Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. Contractor shall pay the FQHC or RHC at minimum the encounter rate.

10.10.6. Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 12.

10.10.6.1. **DELIVERABLE:** FQHC and RHC Encounter Data

10.10.6.2. **DUE:** Within 30 days before the end of each calendar year quarter

10.10.7. 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.

10.10.8. 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).

10.11. IHCP Reimbursement

10.11.1. Contractor shall reimburse any IHCP enrolled in Medicaid as an FQHC but not a Network Provider at least the encounter rate.

10.11.2. Contractor shall reimburse IHCPs not enrolled in Medicaid as an FQHC, regardless of whether they are Network Providers, the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.

10.11.3. 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.

10.12. Physician Incentive Plans

10.12.1. Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

10.12.1.1. Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

10.12.1.2. Contractor shall only operate physician incentive plans if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

10.12.1.3. If Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

10.12.1.4. **DELIVERABLE:** Physician Incentive Plan

10.12.1.5. **DUE:** On the Operational Start or upon implementation of a physician incentive plan

10.13. Third Party Payer Liability

10.13.1. Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing covered services under this Contract. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

10.13.2. Potential liable third parties shall include any of the sources identified in 42 CFR § 433.138 relating to identifying liable third parties. Contractor shall coordinate with the Department to provide information to the Department regarding commercial third party resources.

10.13.3. In the case of commercial health coverage, Contractor shall notify the Department's fiscal agent, by telephone or electronically via the provider portal of any third party payers, excluding Medicare, identified by Contractor. If the third party payer is Medicare, Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number electronically via the fiscal agent's provider portal. If the Member has health insurance coverage other than Medicare, Contractor shall submit to the Department's fiscal agent the following information:

10.13.3.1. Member's Medicaid identification number.

10.13.3.2. Member's full name.

10.13.3.3. Identification of the health carrier or health plan.

10.13.3.4. Member's health plan identification and group numbers.

10.13.3.5. Policy holder's full name.

10.13.3.5.1. **DELIVERABLE:** Third Party Resource Identification

10.13.3.5.2. **DUE:** Within five Business Days electronically to the fiscal agent's provider portal from the time when the third party resource is identified by Contractor.

10.13.4. 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.

10.13.5. Contractor shall also inform its Members that failure to follow Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that Contractor would have been liable to pay. If Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to Contractor or the Network Provider for payment or cost of the care or services.

10.13.6. Contractor shall not restrict access to covered services due to the existence of possible or actual third party liability.

10.13.7. 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.

10.13.7.1. In the case of accident or casualty coverage, Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by Contractor.

10.13.8. Contractor shall limit recoveries to the amount that Medicaid would have paid under Medicaid FFS.

10.13.9. In addition to compensation paid to Contractor under the terms of this Contract, Contractor may retain as income all amounts recovered from third party resources, up to Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

10.13.10. With the exception of Section 9.12. and except when directed by the Department or otherwise specified in contracts between Contractor and Network Providers, Contractor shall pay all applicable co- payments, coinsurance, and deductibles for approved covered services for the Member from the third party resource using Medicaid lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee-for-Service:

10.13.10.1. The sum of reported third party coinsurance and/or deductible or

10.13.10.2. Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

10.13.11. Contractor shall pay, except as otherwise specified in contracts between Contractor and Network Providers, all applicable copayment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and

other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid FFS.

10.13.12. 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.

10.14. Medical Loss Ratio (MLR)

10.14.1. Contractor shall calculate and report the MLR according to the instructions provided on the MLR template and the guidance provided in 42 CFR § 438.8(a).

10.14.2. The first annual measurement period will begin upon the start of the Operational Period of the Contract and end on June 30, 2026.

10.14.3. Subsequent annual measurement periods will align with the state fiscal year, beginning on July 1 and ending on June 30 of the subsequent calendar year.

10.14.4. Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

10.14.4.1. Total incurred claims.

10.14.4.2. Expenditures on quality improvement activities.

10.14.4.3. Expenditures related to activities compliant with program integrity requirements.

10.14.4.4. Non-claims costs.

10.14.4.5. Premium revenue.

10.14.4.6. Taxes.

10.14.4.7. Licensing fees

10.14.4.8. Regulatory fees.

10.14.4.9. Methodology(ies) for allocation of expenditures.

10.14.4.10. Any credibility adjustment applied.

10.14.4.11. The calculated MLR.

10.14.4.12. Any remittance owed to the state, if applicable.

10.14.4.13. A comparison of the information reported with the audited financial report.

10.14.4.14. A description of the aggregation method used to calculate total incurred claims.

10.14.4.15. The number of member months.

10.14.4.16. All data provided by Contractor for the purpose of MLR calculation shall use actual costs.

10.14.5. Contractor shall allow for three months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five months.

10.14.5.1. Contractor shall submit the completed MLR calculation on the Department approved template and provide supporting data and documentation per 42 CFR § 438.8(k), including, but not limited to, all encounters, certified financial statements and reporting, and flat files, in compliance with the Department guidelines, for the measurement period by

January 15. Contractor shall submit encounter claims in compliance with requirements in Section 11.

10.14.5.1.1. **DELIVERABLE:** MLR calculation template and supporting data and documentation

10.14.5.1.2. **DUE:** Annually, by January 15th of each year.

10.14.6. Contractor's Medical Spend will be calculated using audited supplemental data provided in Contractor's annual financial reporting and verified using Encounter Data submitted through flat file submission on a secure server, until such time that the Department deems it appropriate for such Encounter Data submissions to be sent through the interchange.

10.14.6.1. MLR Target: Contractor shall have an MLR of at least 85%. Contractor shall calculate a cohort specific and plan-wide MLR for each SFY using the template provided by the Department.

10.14.6.2. The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR § 438.8(e)) to the denominator (as defined in accordance with 42 CFR § 438.8(f)).

10.14.7. Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro- rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

10.14.7.1. Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

10.14.7.2. Contractor shall ensure that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense.

10.14.7.3. Contractor shall ensure that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, are borne solely by the reporting entity and are not apportioned to the other entities.

10.14.7.4. The numerator is the sum of Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's fraud reduction activities.

10.14.7.5. Contractor shall round the MLR to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

10.14.7.6. Contractor shall aggregate data for all Medicaid eligibility groups covered under this Contract.

10.14.7.7. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse the Department the difference using the following formula:

10.14.7.8. Reimbursement amount shall equal difference between the adjusted earned revenue and the net qualified medical expenses divided by the MLR Target as specified in federal regulations 42 CFR § 438.8(f)(2)(vi).

10.14.7.9. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to Contractor of the amount due, pursuant to 10 CCR

2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

10.14.7.9.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

10.14.7.9.2. 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 lower than the MLR Target, or 85%. If Contractor does not meet any MLR Quality Targets, then the Adjusted MLR Target is equal to the MLR Target, 89%.

10.14.7.9.3. An Adjusted MLR can only be earned if 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 Contractor at least two resubmission opportunities to correct errors within the term of the 12- month contract period prior to disqualifying Contractor for MLR measure incentives.

10.14.8. MLR Quality Targets

10.14.8.1. Contractor shall participate in the measurement and reporting of MLR quality metrics required by the Department for Contractor's adjusted MLR, with the expectation that this information will be placed in the public domain.

10.14.8.2. The Department will provide to Contractor documented calculation methodology for all metrics.

10.14.8.2.1. The Department will release the calculation methodology as a draft and shall provide a comment period of no less than two weeks prior to releasing it as final.

10.14.8.2.2. The Department will determine the final Adjusted MLR metric criteria.

10.14.8.3. Contractor shall provide data, as requested, to enable the Department or its designee to calculate the quality metrics.

10.14.8.4. Contractor shall support Network Providers to collect and report information required to calculate the quality metrics.

10.14.8.5. Contractor shall be held to the following four quality metrics in relation to the adjusted MLR target:

10.14.8.5.1. Initiation and Engagement of Alcohol and Substance Use Disorder Treatment (CMS 137) (1%).

10.14.8.5.2. Depression Screening and Follow-Up (CMS 2) (1%).

10.14.8.5.3. Diabetes HbA1c Poor Control (NQF 0059) (1%).

10.14.8.5.4. Prenatal and Postpartum Care: Prenatal Care (NQF1517); Prenatal and Postpartum Care: Postpartum Care (NQF1517) (1 %).

10.14.8.6. Quality Targets Table B:

Quality Metric	Percentage Adjustment Made to the MLR
To be determined	To be determined
To be determined	To be determined
To be determined	To be determined
To be determined	To be determined
Total Percentage Points	To be determined

10.14.8.6.1. If Contractor's MLR does not meet or exceed the MLR target, then Contractor shall reimburse the Department the difference using the following formula:

10.14.8.6.2. 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).

10.14.8.6.3. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

10.14.8.6.4. Contractor shall submit all encounters, audited financial statements and reporting, and flat files for the measurement period before the Department can validate the MLR.

10.14.8.6.5. Contractor's Medical Spend shall be verified using both Encounter Data submitted through the state's Colorado interChange, as well as audited supplemental data provided in Contractor's annual financial reporting.

10.14.8.6.6. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to Contractor of the amount due, pursuant to 10 CCR 2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

10.14.8.7. Subcontracted Claims Adjudication Activities

10.14.8.7.1. Contractor shall require any subcontractors providing claim adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

10.14.8.7.2. 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, Contractor shall:

10.14.8.7.2.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

10.14.8.7.2.2. Submit a new MLR report meeting the applicable requirements.

10.14.8.7.2.2.1. **DELIVERABLE:** MLR Calculation Template

10.14.8.7.2.2.2. **DUE:** Annually on January 31

10.14.8.7.3. To the extent that Contractor has access to identifiable, Member-level clinical quality measure (CQM) data relevant to the MLR Quality Targets in an electronic format, Contractor shall share this data with the Department. Contractor will work with the Department to establish an appropriate format and method of data transfer.

10.14.9. Medicaid Reporting Template

10.14.9.1. Contractor shall submit an Annual Certified Rate Setting Financial Template that provides a summary of Contractor's financial data for the rate setting cycle, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief.

10.14.9.2. The Department will provide the Annual Certified Rate Setting Financial Template and an information request list (IRL) to Contractor no less than 60 days in advance of the due date.

10.14.9.3. Contractor shall not modify the Annual Certified Rate Setting Financial Template, unless written approval is provided by the Department, and shall submit supporting data and documentation as outlined in the IRL to provide clarity and detail.

10.14.9.4. Contractor shall submit any requested supporting data and documentation to the Department and the designated outside vendor within seven business days of the Department's request.

10.14.9.4.1. **DELIVERABLE:** Annual Certified Rate Setting Financial Template with supporting data and documentation listed in the IRL

10.14.9.4.2. **DUE:** Annually, by November 15th of each year

10.15. Medicaid Payment in Full

10.15.1. Except as allowed in the Contract, Contractor shall not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf, for Covered Services provided pursuant to this Contract.

10.15.2. Except as allowed in the Contract, Contractor shall ensure that all of its Subcontractors and Network Providers do not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf other than Contractor, for covered services provided pursuant to this Contract.

10.15.3. This section shall not be construed to limit the ability of any of Contractor's Subcontractors or Network Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Network Provider and Contractor.

10.15.4. This provision shall survive the termination of this Contract, for authorized services rendered prior to the termination of this Contract, regardless of the reason for the termination. This provision shall be construed to be for the benefit of Contractor's Members.

10.15.5. For fees or premiums charged by Contractor to Members, Contractor may be liable for penalties of up to $25,000.00 or double the amount of the charges, whichever is greater. The Department will deduct from the penalty the amount of overcharge and return it to the affected Members. Federally Qualified Healthcare Center (FQHC) Visits

10.15.6. Contractor shall not charge Members co-pays for the following services:

10.15.6.1. Inpatient hospital services.

10.15.6.2. Outpatient Hospital Services.

10.15.6.3. Optometrist Visits.

10.15.6.4. Podiatrist Visits.

10.15.6.5. Primary Care Physician and specialist services.

10.15.6.6. Rural Health Clinic Visits.

10.15.6.7. Federally Qualified Healthcare Center (FQHC) Visits.

10.15.6.8. DME/Disposable Supply Services.

10.15.6.9. Laboratory services.

10.15.6.10. Radiology services.

10.15.6.11. Prescription drugs or refill services.

10.15.7. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 CFR §§ 95.1 and 95.7, the Department must file all claims for reimbursement of payments to Contractor with CMS within two years after the calendar quarter in which the Department made the expenditure. Contractor and the Department shall work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file Contractor's claims or capitation payments within two years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 CFR § 95.19, no claims or capitations will be paid to Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from Contractor all claims, and capitations paid to Contractor for any period of time disallowed by CMS.

10.15.8. Contractor shall meet the requirements of FFS timely payment, per 42 CFR § 447.46. Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities within 20 days of the date of Contractor's receipt of the request for reimbursement. Contractor shall pay 99% of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities within 45 days of the date of Contractor's receipt of the request for reimbursement.

10.15.8.1. 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 from in Contractor'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.

10.15.8.1.1. **PERFORMANCE STANDARD**: 90% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities were paid by Contractor within 20 days of the date of Contractor's receipt of the request for reimbursement.

10.15.8.1.2. **PERFORMANCE STANDARD**: 98% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities were paid by Contractor within 45 days of the date of Contractor's receipt of the request for reimbursement.

10.15.9. Contractor shall ensure that the date of receipt is the date that Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

10.15.9.1. **DELIVERABLE:** Timely Clean Claims Payment Report

10.15.9.2. **DUE:** Quarterly, within 45 days following the end of the quarter for which the report covers

11. DATA ANALYTICS AND CLAIMS PROCESSING SYSTEMS

11.1. Overview

11.1.1. Contractor shall use data and analytics to successfully operate the ACC.

11.1.2. Contractor shall possess the resources and capabilities to leverage existing data systems and analytics tools, including predictive analytics, or create new ones as necessary to perform the Work, conscious to avoid the creation of duplicative systems.

11.1.2.1. Contractor shall use current and historical data to identify opportunities for clinical and Care Coordination interventions to improve quality and cost outcomes.

11.1.3. Contractor shall leverage the Department provided tools and data in conjunction with Contractor's data analytic resources to distribute data to Network Providers and partners in the Health Neighborhood in a manner that makes it easy for Providers to implement interventions that can improve Member health and outcomes, as well as Network Provider performance.

11.1.4. Contractor shall submit all requested data elements to support deliverable and performance standard validation in a format and frequency determined by the Department.

11.1.4.1. **DELIVERABLE:** Data element file(s)

11.1.4.2. **DUE:** To be determined in collaboration with Contractor and Department

11.1.5. Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern, and apply the information to make changes and improve the health of Contractor's Members.

11.2. Department Provided Tools and Resources

11.2.1. Contractor shall use tools provided by the Department, including those currently in development, and other available resources to monitor provider performance across key cost and utilization metrics, and support Members in accessing needed care and supports. The existing tools provided by the Department include, but are not limited to, the following:

11.2.1.1. interChange

11.2.1.1.1. Contractor shall maintain an interface that enables Contractor to use the interChange Provider Portal to retrieve eligibility, enrollment and attribution information for Members.

11.2.1.1.1.1. At a minimum, Contractor shall have the capabilities to utilize and process HIPAA standard transactions, such as, but not limited to, the 834 form.

11.2.1.2. Enterprise Data Warehouse

11.2.1.2.1. Contractor shall use the EDW and the Department's specified secure file transfer server to access Member claims, roster reports, and raw data, as well as a variety of custom reports to conduct population health management and support Member Care Coordination.

11.2.1.2.2. Contractor shall leverage custom data feeds including, but not limited to the following, in order to perform the Work:

11.2.1.2.2.1. Weekly vaccine record reports from the Colorado Immunization Information System.

11.2.1.2.2.2. Bimonthly judicial rosters of Members that have recently or will shortly exit the probation system.

11.2.1.2.2.3. Daily Colorado Department of Corrections reports of incarcerated persons that may be released within the next 90 days and persons who were released within the past 30 days.

11.2.1.2.2.4. Daily D-SNP admission files from D-SNP Hospitals and Skilled Nursing Facilities.

11.2.1.2.3. Contractor shall have the capacity to share data via MOVEit to the EDW in accordance with agreed upon file specifications and Department security standards. Such data may include Member-level Care Coordination information and utilization management performance.

11.2.1.3. PPQM

11.2.1.3.1. Contractor shall use the PPQM tool to access Contractor's and Network Providers' performance on NCQA-certified HEDIS measures and CMS Core Measures derived from Medicaid claims data and other available sources.

11.2.1.3.2. Contractor shall access standard analytics and reports from the PPQM tool, including Member and attribution lists, trended KPI data, nationally recognized quality and utilization measures, and cost data.

11.2.1.3.3. Contractor may design queries and searches it requires within the PPQM tool to support Contractor's population health management strategy and interventions.

11.2.1.3.4. Contractor shall support and encourage Network Provider use of the Provider- facing web portal that is part of the PPQM tool. The web portal will provide information on Member rosters, gaps in care reporting, cost data, and Provider performance on ACC-certified HEDIS measures and CMS Core Measures derived from Medicaid claims data and other available sources.

11.2.1.4. 42 CFR Part 2 Data

11.2.1.4.1. The Department will provide Contractor with Part 2 Data for Members enrolled with Contractor, subject to the limitations and requirements contained in this contract provision and 42 CFR Part 2.

11.2.1.4.1.1. Contractor shall only use the Part 2 Data received from the Department for two specific purposes:

11.2.1.4.1.1.1. To assess calculation and payment for performance measures.

11.2.1.4.1.1.2. To provide Care Coordination and/or case management services in support of treatment payment or health care operations.

11.2.1.4.1.2. Contractor shall not use the Part 2 Data for any other purpose unless appropriate consent is obtained pursuant to 42 CFR Part 2.

11.2.1.4.1.3. Contractor is fully bound by the provisions of 42 CFR Part 2 upon receipt of the Part 2 Data:

11.2.1.4.1.3.1. Consistent with 42 CFR § 2.32(a)(1), this Part 2 Data will be disclosed to Contractor from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit Contractor from making any further disclosure of information in this record that identifies a patient as having or having had a SUD 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 SUD, except as provided at §§ 2.12(c)(5) and 2.65.

11.2.1.4.1.3.2. Contractor shall implement appropriate safeguards, including written policies and procedures, to prevent unauthorized uses and disclosures of 42 CFR Part 2 data. These policies and procedures shall be documented and reported in Contractor's Data Governance Policy.

11.2.1.4.1.3.3. Contractor shall immediately report any unauthorized uses, disclosures, or breaches of Part 2 Data to the Department.

11.2.1.4.1.3.4. Contractor may only redisclose Part 2 Data to a third party if the third party is a contract agent of Contractor, helping to perform its duties under the Contract, and the contract agent only discloses the information back to Contractor or to the Department.

11.2.2. Additional Data Feeds

11.2.2.1. Contractor shall develop and implement processes to receive and process the following data feeds and to act on the information as expeditiously as possible to address Member needs and improve quality performance.

11.2.2.2. Contractor shall receive direct ADT data feeds from one of Colorado's regional health information exchanges.

11.2.2.3. Contractor shall receive and process the Nurse Advice Line data feed from the Nurse Advice Line contractor.

11.2.2.3.1. Contractor shall distribute information from the Nurse Advice Line to the appropriate Network Provider for follow-up by the Network Provider.

11.2.2.3.2. For Members who were referred to the ED by the Nurse Advice Line but who do not appear to have received follow up care, Contractor shall have policies and procedures to inform the Member's designated PCMP or for Contractor to outreach the Member as timely as possible to assess whether the Member needs care or assistance accessing appropriate care.

11.2.2.4. Contractor shall receive the Inpatient Hospital Transitions data feed from the Department.

11.2.2.5. Colorado Social Health Information Exchange (Co-SHIE)

11.2.2.5.1. Contractor shall participate in and monitor activities for the state design and implementation of the Co-SHIE being developed in collaboration with the Office of eHealth Innovation.

11.2.2.5.2. Contractor shall adopt interoperable technologies as needed to effectively connect to the statewide Co-SHIE for screening, referral, and population health analytics.

11.2.2.5.3. As the Co-SHIE tool is implemented and evolves, Contractor shall participate in Co-SHIE through activities that may include:

11.2.2.5.3.1. Receiving referrals for Care Coordination and other services,

11.2.2.5.3.2. Sending referrals to community resources and other external partners,

11.2.2.5.3.3. Coordinating care within cross-organizational teams, and

11.2.2.5.3.4. Providing data and analytics to support regional population health analytics in collaboration with state agencies, local public health agencies, and other trusted partners.

11.2.2.6. As the following tools continue to be developed, Contractor shall work with the Department to receive and process data from the following:

11.2.2.6.1. AssureCare Care and Case Management Tool.

11.2.2.6.2. EConsult.

11.2.2.6.3. Prescriber Tool.

11.2.2.6.4. Cost and quality referral indicators.

11.3. MCO Maintained Systems

11.3.1. 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.

11.3.2. Contractor shall ensure that it meets all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 CFR Part 2, 45 CFR § 160, 162 and 164, HIPAA as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/HITECH Act (P.L. 111-

005), and State of Colorado Cyber Security Policies. See Colorado Cyber Security Policies at http://oit.state.co.us/ois/policies.

11.3.3. Contractor shall control the use or disclosure of PHI as required by the HIPAA BAA or as required by law. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the HIPAA privacy requirements.

11.3.4. Contractor shall create a data governance policy that describes the circumstances when Contractor shall allow other entities, including Providers and Health Neighborhood organizations, full access to Member level data.

11.3.4.1. Contractor shall update the data governance policy annually and provide to the Department upon request.

11.3.4.1.1. **DELIVERABLE:** Updated Data Governance Policy

11.3.4.1.2. **DUE:** As requested by Department

11.3.5. Contractor shall integrate select Contractor maintained systems with the Department's Enterprise Solutions Integrator (ESI) after the ESI is fully implemented and operational. Contractor shall collaborate with the Department to ensure integrated systems use standardized data elements.

11.3.6. Care Coordination Tool

11.3.6.1. Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. Contractor shall make it available for use by small independent Providers and Care Coordinators that have limited or no access to a Care Coordination tool at no cost to those providers.

11.3.6.2. Contractor shall ensure that the Care Coordination Tool:

11.3.6.2.1. Works on mobile devices.

11.3.6.2.2. Supports HIPAA and 42 CFR Part 2 compliant data sharing.

11.3.6.2.3. Provides role-based access to providers and Care Coordinators.

11.3.6.3. Contractor shall ensure the Care Coordination Tool can collect and aggregate, at a minimum, the following information:

11.3.6.3.1. Name and Medicaid ID of Member for whom Care Coordination interventions were provided.

11.3.6.3.2. Age.

11.3.6.3.3. Gender identity.

11.3.6.3.4. Race/ethnicity.

11.3.6.3.5. Name of entity or entities providing Care Coordination, including the Member's choice of lead care coordinator if there are multiple coordinators.

11.3.6.3.6. Care Coordination notes, activities and Member needs.

11.3.6.3.7. Stratification level.

11.3.6.4. Contractor shall ensure that its Care Coordination Tool has the capacity to capture information that can aid in the creation and monitoring of a care plan for the Member, such as clinical history, medications, social supports, resources for health- related social needs, and Member goals.

11.3.6.5. Contractor shall collect and be able to report to the Department the information from the Care Coordination Tool for all Network Providers utilizing the Care Coordination Tool. Although Network Providers and subcontracted Care Coordinators may use their own data collection tools, Contractor shall require them to collect and report on similar or identical data fields.

11.3.6.6. Contractor shall work with the Department to plan for how the Care Coordination Tool can exchange data with other Department tools such as the EDW and the LTSS Case Management system.

11.3.7. Telemedicine Supports for Members

11.3.7.1. Contractor shall support Member use of existing telemedicine technology.

11.3.7.2. Contractor shall possess and maintain a telemedicine option for Members to ensure all Members have access to telemedicine supports.

11.3.7.3. Contractor shall inform members of telehealth options available to them. Contractor shall target communications to Members in Rural Counties and Counties with Extreme Access Considerations and Members attributed to PCMPs that do not have their own telemedicine technology supports.

11.3.8. Claims Processing System for Capitated Physical Health Benefit

11.3.8.1. Contractor shall maintain a claims processing system to reimburse providers for Covered Services under the Capitated Physical Health Benefit and produce encounter claims.

11.3.8.2. Contractor shall ensure that its claims processing has the capability to process claims using the billing procedure codes specified in the State Billing Manual. The State Billing Manual can be found on the Department's website.

11.3.8.2.1. Contractor shall resolve any identified claims processing systems errors as expeditiously as possible, but no longer than six months from the date the error is identified.

11.3.8.2.1.1. **PERFORMANCE STANDARD**: Contractor's claims processing system shall comply with quarterly updates to the State Billing Manual within 30 calendar days from the start of the quarter in which the Billing Manual update is effective or 60 calendar days from when final changes are made available to Contractor, whichever is later.

11.3.8.2.1.2. **PERFORMANCE STANDARD**: 95% of claims processing system errors identified by Contractor, Department or Network Provider are fixed within 30 calendar days of Contractor identifying or being informed of the claims processing system error, with an additional 15 calendar days for claims reprocessing.

11.3.8.3. Encounter Data Reporting through interChange

11.3.8.3.1. Contractor shall submit all Encounter Data on all State Plan and 1915(b)(3) Waiver services included within the Capitated Physical Health Benefit electronically, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

11.3.8.3.2. Contractor shall submit Encounter Data in the ANSI ASC X12N 837 format directly to the Department's Fiscal Agent using the Department's data transfer protocol. Contractor shall submit any 837 format encounter claims, reflecting paid, adjusted or denied by Contractor, via a regular monthly batch process. Contractor shall submit all encounter claims in accordance with the following:

11.3.8.3.2.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

11.3.8.3.2.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

11.3.8.3.2.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

11.3.8.3.3. Contractor shall submit 95% of all clean encounter claims within 30 days after the month the claim was paid or denied, and 98% of all clean encounter claims within 120 days after the month the claim was paid or denied, following the methodology as agreed upon by the Department and MCEs. Contractor shall submit paid and denied clean Encounter Data into the MMIS each month. The Department will measure performance on a monthly basis.

11.3.8.3.3.1. **PERFORMANCE STANDARD**: 95% of all clean encounter claims were submitted no later than 30 days following the month claim was paid or denied.

11.3.8.3.3.2. **PERFORMANCE STANDARD**: 98% of clean encounter claims were submitted no later than 120 days following the month claim was paid or denied.

11.3.8.3.4. Contractor shall make an adjustment to encounter claims when Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If the Department discovers errors or a conflict with a previously adjudicated encounter claim, Contractor shall adjust or void the encounter claim within 14 calendar days of notification by the Department.

11.3.8.3.5. Contractor shall meet or exceed a 98% reported clean encounter claims acceptance rate for the measurement quarter, following the methodology as agreed upon by the Department and MCEs. The Department will measure performance on a quarterly basis. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation. At the discretion of the Department, or at the request of Contractor, the accuracy rate may be adjusted to account for Department system changes. Contractor shall develop and implement a plan to meet this standard.

11.3.8.3.5.1. **PERFORMANCE STANDARD**: 98% of Contractor's submitted clean encounter claims are accepted for the measurement quarter. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation. Contractor shall not be held accountable for this Performance Standard until SFY 2026-27 or later as determined by the Department.

11.3.8.3.5.2. **PERFORMANCE STANDARD:** Contractor shall achieve a Department and MCE agreed-upon performance target for SFY 2026-27 for the percent of submitted encounters that are determined by the Department's system to be accurately adjudicated, with the goal that by SFY 2027-28 the target is no less than 98%.

11.3.8.3.6. Contractor shall submit all necessary Encounter Data, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR § 438.242.

11.3.8.3.6.1. Contractor shall submit monthly data certifications for all Encounter Data used for rate setting, in compliance with 42 CFR §§ 438.604 and 438.606. Contractor shall ensure that the data certification includes certification that data submitted is accurate, complete and truthful, and that all paid encounters are for Covered Services provided to or for enrolled Members.

11.3.8.3.6.1.1. **DELIVERABLE:** Certified Encounter Data submission

11.3.8.3.6.1.2. **DUE:** Monthly, on the last Business Day of the month the report covers

11.3.8.3.7. Contractor shall submit its raw Encounter Data, excluding data protected by 42 CFR Part 2, to the Colorado All-Payer Claims Database in accordance with the guidelines found in the most current version of the Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide found at http://www.colorado.gov/hcpf.

11.3.8.3.8. Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change data format requirements following consultation with Contractor and retains the right to make the final decision regarding data format submission requirements. Contractor shall have a maximum of 90 days from written communication from the Department to comply with any changes in Department data format submission requirements.

11.3.8.3.9. Contractor shall use enrollment reports to identify and confirm Membership and provide a definitive basis for payment adjustment and reconciliation. Contractor shall ensure that the data transmissions and enrollment reports shall include:

11.3.8.3.9.1. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction.

11.3.8.3.9.2. HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction.

11.3.8.3.9.3. HIPAA X12N 834 Daily Roster.

11.3.8.3.9.4. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

11.3.8.3.9.5. interChange Encounter Reconciliation Report.

11.3.9. Flat File Submission

11.3.9.1. Quarterly, Contractor shall electronically submit a flat file table that contains all encounters for that State Fiscal Year, with one record per encounter, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

11.3.9.1.1. The Department shall provide Contractor with the specifications for the flat file submission.

11.3.9.1.2. The Department shall conduct a quality review of the submission to determine if the flat file meets the required specifications.

11.3.9.1.2.1. **DELIVERABLE:** Certified Quarterly Flat File

11.3.9.1.2.2. **DUE:** Quarterly, on the 10th day of the month following the close of the State Fiscal Quarter.

11.3.9.2. Contractor shall submit a flat file that contains 95% of paid claim lines in the quarter the claims were paid by the Deliverable due date.

11.3.9.2.1. Contractor shall submit a flat file that contains 100% of paid claim lines with the following quarter's submission.

11.3.9.3. Contractor shall be responsible for the accuracy of flat file submissions.

11.3.9.4. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

11.3.10. Annual Submission

11.3.10.1. Contractor shall on an annual basis electronically submit a flat file and data certification certifying the flat file is as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer or Chief Financial Officer or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

11.3.10.1.1. The Department will provide Contractor with the specifications for the annual flat file submission.

11.3.10.1.2. The Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

11.3.10.1.2.1. DELIVERABLE: Certified Annual Flat File

11.3.10.1.2.2. DUE: Annually, by October 31

11.4. Contractor shall notify the Department at least 90 days in advance of any Contractually required system that Contractor will be transitioning to a different or new system implementation.

11.5. Interoperability Rule

11.5.1. Contractor shall implement and maintain a secure, standards-based application program interface (API) aligning with the Department's implementation timeline. The API shall include at minimum, the following capabilities:

11.5.1.1. Be available through a public-facing digital endpoint on Contractor's website.

11.5.1.2. Include complete and accurate Provider directory information.

11.5.1.2.1. The Provider directory must meet the same technical standards as the patient access API, excluding the security protocols related to user authentication and authorization.

11.5.1.2.2. The Provider directory information shall be updated no later than 30 calendar days after the Department or Contractor receives the Provider directory information or updates to Provider directory information.

11.5.1.3. Comply with the requirements of 42 CFR §§ 438.242, 45 CFR § 170.215, as well as the Provider directory information specified in § 438.10.

11.5.1.4. Provide current Members, or their personal representatives, with access to claims and Encounter Data within one Business Day of receipt, including:

11.5.1.4.1. Adjudicated claims, including data for payment decisions that may be appealed, were appealed, or are in the process of appeal.

11.5.1.4.2. Provider remittances and beneficiary cost-sharing pertaining to adjudicated claims.

11.5.1.4.3. Services and items provided in treatment.

11.5.1.5. Clinical information within one Business Day of receipt, if collected and maintained by Contractor, including:

11.5.1.5.1. Diagnoses and Related Codes.

11.5.1.5.2. Medical Records and Reports.

11.5.1.5.3. Laboratory Test Results.

11.5.1.6. Information about covered outpatient drugs within one Business Day after the effective date of any update, including:

11.5.1.6.1. Formulary of prescription drugs and costs to the Member.

11.5.1.6.2. Preferred drug list information.

11.5.2. Contractor shall comply with the requirements of 42 CFR § 438.62 by developing and maintaining a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

11.5.3. Contractor shall incorporate the USCDI standards for data classes and elements received from other plans about the Member.

11.5.4. Contractor shall, upon request by a Member:

11.5.4.1. Incorporate into its records Member data with a date of service on or after January 1, 2016, from any other payer that has provided coverage to the Member within the preceding five years.

11.5.4.2. Send all such data to any other payer that currently covers the Member, or a payer that the Member specifically requests to receive the data classes and elements included in the USCDI content standards, any time during a Member's enrollment with Contractor and up to five years after disenrollment.

12. OUTCOMES, QUALITY ASSESSMENT, AND PERFORMANCE IMPROVEMENT PROGRAM

12.1. Overview

12.1.1. Contractor shall use data and analytics as part of its continuous quality improvement strategy for the full range of management, coordination and care activities, including, but not limited to, process improvement, population health management, federal compliance with federal regulations, claims processing, outcomes tracking and cost control.

12.1.1.1. Contractor shall analyze the key cost drivers within Contractor's service area and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

12.1.1.2. Contractor shall report Contractor's findings to the Department in a timely manner, this may be using an appropriate existing Deliverable, such as the Annual Contracted Network Management Strategic Plan; through an appropriate meeting with the Department, such as the Quarterly Leadership Meeting; or through an ad hoc communication vehicle.

12.1.1.3. Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

12.1.2. Contractor shall implement and maintain an ongoing comprehensive quality assessment and performance improvement program (Quality Improvement Program) that complies with 42 CFR § 438.310-370.

12.1.3. Contractor shall take into consideration the federal definition of quality when designing its program. CMS defines quality as the degree to which Contractor increases the likelihood of desired outcomes of the Members through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge and interventions for performance improvement.

12.1.4. Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the PCCM Entity and PIHP.

12.2. Quality Improvement Program

12.2.1. Contractor's Quality Improvement Program shall align with 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 all of the following:

12.2.1.1. Performance improvement projects.

12.2.1.2. Collection and submission of performance measurement data, including Member experience of care.

12.2.1.3. Mechanisms to detect both underutilization and overutilization of services.

12.2.1.4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department.

12.2.1.5. Quality of care grievances.

12.2.1.6. External Quality Review.

12.2.1.7. Advisory committees and learning collaboratives.

12.2.2. Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how Contractor plans to implement its Quality Improvement Program. Contractor shall make reasonable changes to the Quality Improvement Plan at the Department's direction.

12.2.2.1. **DELIVERABLE:** Quality Improvement Plan

12.2.2.2. **DUE:** July 1, 2025

12.2.3. Contractor shall submit an Annual Quality Report to the Department and/or designee, providing updates to Contractor's Quality Improvement Plan and detailing the progress and effectiveness of each component of its Quality Improvement Program. Contractor shall include at minimum, all of the following in the report:

12.2.3.1. A description of the techniques Contractor used to improve its performance.

12.2.3.2. A description of the qualitative and quantitative impact the techniques had on quality.

12.2.3.3. The status and results of each Performance Improvement Project conducted during the year.

12.2.3.4. Lessons learned.

12.2.3.5. Opportunities for improvement.

12.2.3.6. Updates to the Quality Improvement Plan

12.2.3.6.1. **DELIVERABLE:** Annual Quality Report

12.2.3.6.2. **DUE:** Annually, no later than the last Business Day in September, beginning in 2026

12.2.3.7. Contractor shall publicly post its Annual Quality Report.

12.3. Performance Improvement Projects

12.3.1. Contractor shall conduct Performance Improvement Projects designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

12.3.2. Contractor shall complete Performance Improvement Projects on a multiyear cycle, including annual reporting, to facilitate the integration of project findings and information into the overall quality assessment and improvement program, and to produce new information on quality of care each year.

12.3.3. Contractor shall have a minimum of two Performance Improvement Projects chosen in collaboration with the Department that include at minimum, all of the following: one clinical project that may include physical health integration into behavioral health and one non-clinical project.

12.3.3.1. Contractor shall conduct Performance Improvement Projects on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a particular topic.

12.3.4. Contractor shall have the capacity to conduct up to two additional Performance Improvement Projects upon request from the Department.

12.3.5. Contractor shall ensure that Performance Improvement Projects include the following:

12.3.5.1. Measurement of performance using objective quality indicators.

12.3.5.2. Implementation of system interventions to achieve improvement in quality.

12.3.5.3. Evaluation of the effectiveness of the interventions.

12.3.5.4. Planning and initiation of activities for increasing or sustaining improvement.

12.3.6. Contractor shall participate in a Performance Improvement Project learning collaborative at the end of each Performance Improvement Project cycle hosted by the Department that includes sharing of data, outcomes, and interventions.

12.3.7. Contractor shall submit Performance Improvement Projects for validation by the Department's External Quality Review Organization (EQRO) to determine compliance with requirements set forth in 42 CFR § 438.350, and as outlined in External Quality Review Organization Protocol for Validating Performance Improvement Projects document. These requirements include:

12.3.7.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction.

12.3.7.2. Measurement of performance using objective valid and reliable quality indicators.

12.3.7.3. Implementation of system interventions to achieve improvement in quality.

12.3.7.4. Empirical evaluation of the effectiveness of the interventions.

12.3.7.5. Planning and initiation of activities for increasing or sustaining improvements.

12.3.8. Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report.

12.4. Performance Measurement

12.4.1. 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.

12.4.2. Contractor shall consult with the Department to develop measurement criteria, reporting frequency and other performance measurement components. The Department will determine the final measurement criteria.

12.4.3. Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

12.4.4. Contractor shall provide data, as requested, to enable the Department or its designee to calculate the performance measures, unless the data is already in the Department's possession.

12.4.5. Contractor shall support Network Providers and care coordinators to collect and report information required to calculate the performance measures.

12.4.6. Contractor shall track their performance on identified measures monthly through data resources as appropriate.

12.4.7. Contractor shall provide comments regarding any or all of the Department's documented calculation methodologies performance measures.

12.4.8. Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

12.4.9. Contractor shall collect at the request of the Department information from Network Providers necessary to supplement the calculation of CMS Adult and Child Core Measure sets.

12.4.10. Contractor shall have a strategy for supporting Network Providers in achieving the national average performance on the CMS Adult and Child Core Measure sets.

12.4.11. ACC Metrics

12.4.11.1. Contractor shall track and submit data related to the following:

12.4.11.1.1. ACC Key Performance Indicators (KPIs)

12.4.11.1.1.1. Contractor shall be capable of working to improve performance on KPIs. Contractor shall support Network Providers in achieving practice-specific targets for KPIs, as well as work comprehensively to achieve regional KPI performance targets.

12.4.12. Additional Performance Measurement

12.4.12.1. Commitment to Quality Program.

12.4.12.1.1. Contractor shall strive to achieve all the Performance Standards agreed to in the Work. Contractor shall commit to excellence in achieving these Performance Standards by contributing funding in the amounts detailed in this section when Contractor does not achieve annual performance expectations regarding Performance Standards as established and documented annually by the Department.

12.4.12.1.1.1. Contractor shall work with the Department and other MCEs to establish performance targets for specified Performance Standards. The Department reserves the right to set a performance target based on historical data submitted by the MCEs if the MCEs and the Department cannot establish mutual agreement on a performance target.

12.4.12.1.1.2. Contractor and the Department shall agree on the funding distribution methodology no later than six months following the Department's acceptance of Contractor's state Fiscal Year quarter four Quarterly Financial Report. Contractor shall not distribute these funds to either Contractor entities with ownership interest in Contractor, or the Department. Funds shall only be used for intents enumerated in this Work, such as but not limited to, supporting the health neighborhood(s), improving Member health, improving access to care, or efforts to achieve KPI or shared savings goals. Funds shall not be used to enhance provider reimbursement beyond 100% of their contractual terms for timely payment.

12.4.12.1.1.3. Contractor financial contributions made for missing Performance Standard shall be made from Contractor's profit margin, as defined by the difference between total revenue earned through this Work and total expense for annual performance periods as reported through the quarterly financial review process and in alignment with Contractors annual financial forecasted expense allocations.

12.4.12.1.1.4. Contractor shall bear the responsibility of proving that financial contributions are deducted from Contractor's profit margin during the quarterly financial review meetings with the Department.

12.4.12.1.1.5. Contractor shall not pass on the cost of these contributions to the Commitment to Quality Program to Network Providers or Subcontractors that support the Work. Contractor shall not absorb the cost of this reimbursement by reducing staff or resources dedicated to the Work, or other actions that would likely have a negative impact on Members or Network Providers.

12.4.12.1.2. Funding the Commitment to Quality Program

12.4.12.1.2.1. Contractor shall contribute the following amount of funding to the Commitment to Quality Program following a determination by the Department of the number and percent of the Performance Standards Contractor achieved during the previous state fiscal year:

12.4.12.1.2.1.1. Zero percent of Contractor's profit margin if Contractor meets 90% or more of the Performance Standards.

12.4.12.1.2.1.2. Five percent of Contractor's profit margin if Contractor meets 85-89% of the Performance Standards.

12.4.12.1.2.1.3. 15% of Contractor's profit margin if Contractor meets 80-84% of the Performance Standards.

12.4.12.1.2.1.4. 25% of Contractor's profit margin if Contractor meets less than 80% of the Performance Standards.

12.4.12.2. Public Reporting

12.4.12.2.1. Contractor shall improve network performance on Department-determined federal, state, and contract measures that will be reported publicly at least one time annually. The Public Reporting measures may include, but are not limited to, the following:

12.4.12.2.1.1. KPIs.

12.4.12.2.1.2. CMS Adult and Child Core Measure sets.

12.4.12.2.1.3. Clinical and Utilization Measures as relevant, including HEDIS measures that align with other state and federal initiatives.

12.4.12.2.1.4. Member experience of care.

12.4.12.2.1.5. Utilization Management and operational information, including authorizations and denials of services.

12.4.12.3. Healthcare Effectiveness Data and Information Set (HEDIS)

12.4.12.3.1. Contractor shall calculate and submit specified HEDIS measures, and core set measures as required by the Department, as updated by CMS annually. Contractor shall track the CMS core measure set development to ensure reporting on the current measure set. The Department will collaborate with Contractor's quality improvement committee to designate the required measures.

12.4.12.3.2. Contractor shall analyze and respond to results indicated in the HEDIS measures.

12.4.12.3.3. Contractor shall contract with a NCQA certified individual entity to perform an external audit of the HEDIS measures according to HEDIS protocols.

12.4.12.3.4. Any failed audit that nullifies more than three required HEDIS measures is considered non-compliant with this requirement.

12.4.12.3.4.1. During any HEDIS year in which more than three required HEDIS measures are considered not compliant, Contractor shall re-calculate and submit the previously invalid measure rates within 30 days from the date of the invalid measure. Contractor shall ensure those measure rates are audited by an NCQA certified individual entity.

12.4.12.4. Health Equity and Performance Improvement

12.4.12.4.1. Contractor shall disaggregate their performance and utilization data at least by race and ethnicity, language, gender, age, and disability status in strategic priority areas as defined by the Department's Health Equity Plan and make this information available to the Department and stakeholders upon request.

12.4.12.4.2. Contractor shall collaborate with the Department and stakeholders in the development of health equity measures, which may require the addition of new measures or the adjustment of existing measures.

12.4.12.4.3. Over the performance period for any or all performance measures, Contractor shall collaborate with the Department to understand performance results, collect high quality data for measurement, and develop and implement interventions to improve performance results to the benefit of Members and providers.

12.5. Member Experience of Care

12.5.1. Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by Contractor and Network Providers.

12.5.2. Contractor shall use tools to measure Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, call center data, and Grievance and Appeals data.

12.5.3. Contractor shall assist the Department or it's designated vendor with the annual administration of the consumer assessment of healthcare providers and systems survey (CAHPS) and any subsequent survey tool required by CMS for both adults and children.

12.5.3.1. Contractor shall work with the Department to customize CAHPS and to develop a sampling methodology.

12.5.3.2. Contractor shall develop strategies with the Department to increase Member participation in the health plan CAHPS.

12.5.4. Contractor shall use the results and data from CAHPS and all other surveys conducted by Contractor to inform Contractor's Quality Improvement Plan.

12.5.5. Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

12.5.5.1. Contractor shall monitor interventions and report on them at least one time annually in the Annual Quality Report.

12.5.5.2. Contractor shall develop a corrective action plan for a Network Provider when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is substantiated.

12.5.6. Contractor shall design and document a member experience of care strategy as part of the Annual Quality Plan and Report that shall include, but is not limited to, the following information:

12.5.6.1. Strategy to survey Members who accessed services during a recent period of time as defined by Contractor, but no less than one time annually.

12.5.6.2. Strategy to survey Members who were enrolled with Contractor during the previous 12 months.

12.5.6.3. Process to analyze Contractor's call center information and Grievances and Appeals data to better understand Members' experience.

12.5.6.4. Process to assist the Department with survey implementation.

12.5.6.5. Analysis of findings regarding Member experience from the previous year and modifications Contractor has made to its operations in response to these findings.

12.5.6.6. Contractor's interventions and any corrective action plans with specific network providers based on Member experience findings.

12.5.6.7. Lessons learned from Contractor's activities to collect information about Member experience.

12.6. Mechanisms to Detect Overutilization and Underutilization of Services

12.6.1. Contractor shall implement and maintain mechanisms to detect overutilization and underutilization of services, and to assess the quality and appropriateness of care furnished to Members, including Members with special health care needs. Contractor may incorporate mechanisms developed for Contractor's Utilization Management program.

12.6.1.1.1.1.

12.7. External Quality Review

12.7.1. Contractor shall participate in an annual 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 CFR § 438 and the CMS mandatory activity protocols.

12.7.2. Contractor shall participate in an external quality review that includes a review of the:

12.7.2.1. Contractor's activities in its role as an MCO

12.7.2.2. Contractor's administration of the Contract as an integrated program.

12.7.3. Contractor shall participate in an annual external review that may include, but is not limited to, the following:

12.7.3.1. Medical Record review. For external review activities involving Medical Record abstraction, Contractor shall obtain copies of the Medical Records from the sites in which the services reflected in the encounter occurred at no cost to the Department or its vendors.

12.7.3.2. Performance improvement projects and studies.

12.7.3.3. Surveys.

12.7.3.4. Network adequacy during the preceding 12 months.

12.7.3.5. Calculation and audit of quality and utilization indicators.

12.7.3.6. Quality of Care Grievance reviews

12.7.3.7. Administrative data analyses.

12.7.3.8. Review of individual cases.

12.7.3.9. Care Coordination record review.

12.7.3.10. Provider site visits.

12.7.3.11. Encounter Data validation.

12.7.4. Contractor shall participate in the development and design of any external independent review studies to assess and assure quality of care. The final study specifications shall be at the discretion of the Department.

12.7.4.1. **PERFORMANCE STANDARD**: Contractor shall receive an aggregate score of 90% or greater on the annual compliance audit conducted by the external quality review organization.

12.8. Advisory Committees and Learning Collaboratives

12.8.1. To determine whether the Program is effectively serving Members and providers, Contractor shall participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the Program overall and guiding the improvement of program performance.

12.8.2. Statewide Program Improvement Advisory Committees (PIAC)

12.8.2.1. Contractor shall participate in a statewide PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and providers in the Program. For the statewide PIAC, Contractor shall:

12.8.2.1.1. Designate one of Contractor's Key Personnel to attend monthly meetings.

12.8.2.1.2. Nominate one representative from one of Contractor's regional PIACs or MACs to serve as a member of the statewide PIAC and have processes to make sure representatives consistently attend and participate in monthly meetings. The representative cannot be employed by Contractor.

12.8.3. Regional PIAC

12.8.3.1. Contractor shall create at least one Regional PIAC within Contractor's service area to engage stakeholders and solicit guidance regarding the different needs and characteristics of the areas served.

12.8.3.2. Contractor shall confirm that the PIAC includes, at a minimum, all of the following stakeholder representatives:

12.8.3.2.1. Members.

12.8.3.2.2. Members' families and/or caregivers.

12.8.3.2.3. PCMPs.

12.8.3.2.4. Behavioral Health Providers.

12.8.3.2.5. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

12.8.3.2.6. Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests.

12.8.3.3. Contractor's Regional PIAC shall have the following responsibilities:

12.8.3.3.1. Review Contractor's Deliverables.

12.8.3.3.2. Discuss program policy changes and provide feedback.

12.8.3.3.3. Provide representatives for the statewide PIAC.

12.8.3.3.4. Review Contractor's and Program's performance data.

12.8.3.4. Contractor shall have documented policies and procedures describing how its Regional PIACs address the following requirements:

12.8.3.4.1. Be directed and chaired by one of Contractor's Key Personnel as approved by the Department.

12.8.3.4.2. Have a formal, documented membership and governance structure that is posted on Contractor's website for public viewing.

12.8.3.4.3. Have a formal budget for the operations of the Regional PIAC, which may include a strategy for reimbursing Member participation.

12.8.3.4.4. Conduct regular meetings, no less than quarterly, in a format that encourages the active participation of Members and their family or caregivers and best meets the needs of Contractor's service area.

12.8.3.4.4.1. Contractor shall utilize facilitation methods and resources to create an environment in which Members and their family or caregivers feel safe providing feedback.

12.8.3.4.5. Open all scheduled meetings to the public.

12.8.3.4.6. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

12.8.3.4.7. Accommodate individuals with disabilities.

12.8.4. Member Advisory Committee (MAC)

12.8.4.1. Contractor shall create at least one regional MAC within Contractor's service area to engage stakeholders and solicit guidance regarding the different needs and characteristics of the areas served.

12.8.4.2. Contractor's MACs shall have the following responsibilities:

12.8.4.2.1. Discuss the Member experience of Contractor's activities and the delivery of Medicaid services within Contractor's region.

12.8.4.2.2. Discuss Contractor's and its Network Providers activities to advance culturally competent, accessible care within Contractor's service area.

12.8.4.2.3. Discuss Contractor's policy changes and provide feedback.

12.8.4.2.4. Provide representatives for the statewide PIAC.

12.8.4.2.5. Review Contractor's and Program's performance data.

12.8.4.2.6. Review Member materials and provide feedback.

12.8.4.3. Contractor shall have documented policies and procedures describing how its Regional MACs address the following requirements:

12.8.4.3.1. Be directed and chaired by someone experienced in health equity, cultural and disability responsiveness, communication and Member engagement.

12.8.4.3.2. Have a formal budget for the operations of the MAC, which may include a strategy for reimbursing Member participation.

12.8.4.3.3. Hold regular meetings, no less than quarterly, in a manner that supports the active participation of Members and their family or caregivers and best meets the needs of Contractor's service area.

12.8.4.3.4. Post the agenda of each meeting on Contractor's website within seven days in advance of each meeting.

12.8.4.3.5. Post de-identified minutes of each meeting on Contractor's website within 30 days of each meeting.

12.8.4.3.6. Accommodate individuals with disabilities.

12.8.5. Regional Health Equity Committee

12.8.5.1. Contractor shall establish a Regional Health Equity Committee that shall discuss issues of equity and health disparities within Contractor's service area.

12.8.5.2. Contractor shall ensure that the Regional Health Equity Committee includes, at a minimum, the following stakeholder representatives:

12.8.5.2.1. Members, including Members with disabilities.

12.8.5.2.2. PCMPs.

12.8.5.2.3. Behavioral health providers.

12.8.5.2.4. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

12.8.5.2.5. Advocacy organizations.

12.8.5.2.6. Community organizations, including local public health and child welfare agencies.

12.8.5.3. Contractor shall strive to ensure the membership of the Regional Health Equity Committee appropriately represents the demographic breadth of the region, with a focus on recruiting Black, Indigenous and Other People of Color (BIPOC), individuals with disabilities, and other focus populations identified in Contractor's Health Equity Plan.

12.8.5.4. Contractor's Regional Health Equity Committee shall have the following responsibilities:

12.8.5.4.1. Discuss health equity and accessibility challenges within Contractor's service area and provide recommendations for addressing health disparities.

12.8.5.4.2. Inform the design of Contractor's Health Equity Plan and provide oversight of the plan's implementation.

12.8.5.4.3. Provide feedback on Contractor's and its Network Providers activities to advance health equity and accessibility within Contractor's service area, particularly regarding Member engagement activities.

12.8.5.4.4. Review Contractor's and Program's health equity performance data.

12.8.5.5. Contractor shall ensure that its Regional Health Equity Committee:

12.8.5.5.1. Be directed and chaired by Contractor's Health Equity Officer.

12.8.5.5.2. Have a formal budget for the operations of the Regional Health Equity Committee, which may include a strategy for reimbursing Member participation.

12.8.5.5.3. Hold regular meetings, no less than two times annually, in a manner that supports the active participation of Members and individuals of different cultures, ethnicities, language preferences, and abilities.

12.8.5.5.4. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

12.8.5.5.5. Accommodate individuals who speak a primary language other than English.

12.8.5.5.6. Accommodate individuals with disabilities.

12.8.6. Quality Improvement Committee

12.8.6.1. Contractor shall have its Quality Improvement Director or their designee 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.

12.8.7. ACC Operations Meeting

12.8.7.1. Contractor shall have its regional Contract Manager and other relevant staff members participate with Department staff and other RAE staff in the Department's ACC Operations meetings held at least one time per month. The Operations Meeting provides an opportunity for Contractor to learn about programs and policies impacting the ACC and Contractors, as well as to provide input and feedback regarding Department policies and the operations of the ACC.

12.8.8. Operational Learning Collaborative.

12.8.8.1. Contractor shall participate in Department Operational Learning Collaborative meetings to monitor and report on Contractor and ACC activities including, at minimum, all of the following.

12.8.8.1.1. Wellness activities.

12.8.8.1.2. Provider payment models.

12.8.8.1.3. Health Promotion and Population Stratification and Management.

12.8.8.1.4. Member engagement.

12.8.8.1.5. Activities to promote health equity, cultural competency and disability accessibility within Network.

12.8.8.1.6. Health Neighborhood and Community development.

12.8.8.1.7. Provider support and practice transformation.

12.8.8.1.8. Data analytics.

12.8.8.1.9. Care Coordination, including cross-agency, cross-system activities.

12.8.8.1.10. Health information initiatives and technologies.

12.8.8.1.11. Strategies used to address social determinants of health.

12.8.8.1.12. Transitions of care, including hospital discharge and LTSS Members transitioning to the community.

12.8.8.2. Contractor shall share best practices and lessons learned with other RAEs while gaining insights from them to improve implementation of the ACC.

12.8.8.3. Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

12.8.9. Cost Collaborative

12.8.9.1. Contractor shall actively participate in a Department-led Cost Collaborative to identify and control unnecessary and/or avoidable costs within the Medicaid Program. One critical objective of this collaborative is to align incentives and focus across the health continuum from value-based payment strategies to quality performance objectives and care coordination risk stratification hierarchy.

12.8.9.2. Contractor will receive, process, and analyze Statewide data and shall work collaboratively with the Department to identify trends and potentially avoidable costs.

12.8.9.3. Contractor shall work with the Department to identify and review service area specific:

12.8.9.3.1. Cost outliers.

12.8.9.3.2. Programs not meeting engagement or savings targets.

12.8.9.3.3. System challenges impacting performance.

12.8.9.3.4. Gaps in data and information.

12.8.9.3.5. Standardized cost dashboards.

12.8.9.4. To support the Cost Collaborative, Contractor shall:

12.8.9.4.1. Assist in improving the flow of necessary data and information between Contractor, their Network Providers and the Department.

12.8.9.4.2. Identify early areas of opportunity for cost management.

12.8.9.4.3. Share ideas regarding best and promising practices and the return on investment.

12.8.10. Program and Data (PAD) Meeting

12.8.10.1. Contractor shall actively participate in Department-led Program and Data Meetings to analyze Contractor's performance on quality metrics and other Department- identified priorities that may include outcomes of collaboration with CMAs and progress on outcome goals related to care coordination.

12.8.10.2. Contractor shall staff PAD meetings with data analytic, quality, and program staff educated in the topic being explored for each meeting.

12.8.10.3. Contractor shall conduct analyses in advance of each meeting and share Contractor's findings which shall include, at minimum, all of the following:

12.8.10.3.1. Performance trends.

12.8.10.3.2. Data gaps.

12.8.10.3.3. Promising practices and lessons learned.

12.8.10.3.4. Areas of opportunity.

12.8.10.3.5. Recommendations for how the Department can better support Contractor around the specific topic.

12.8.10.4. Contractor shall provide input and feedback regarding quality improvement priorities and measurements.

12.8.11. RAE Quarterly Leadership Meeting

12.8.11.1. Contractor shall collaborate with the Department on setting the agenda and preparing for a quarterly meeting with Department leadership (to include the Executive Director) to review Contractor performance that includes, but is not limited to, the following:

12.8.11.1.1. Care Coordination.

12.8.11.1.2. Administration of the Capitated Physical Health Benefit.

12.8.11.1.3. Population Health Management Report.

12.8.11.1.4. Network Adequacy Report.

12.8.11.1.5. Grievances and Appeals.

12.8.11.1.6. Member Engagement.

12.8.11.1.7. Administrative Payment Arrangements.

12.8.11.1.8. Client Over-Utilization Program.

12.8.11.1.9. Highlights of work with Health Neighborhood organizations.

12.8.11.1.10. Areas of opportunity and challenge to be addressed for Contractor to improve performance, including barriers to properly address those opportunities and challenges.

12.8.11.1.11. Provider areas of opportunity and where the Department can be of assistance.

12.9. Ad Hoc Quality Reports

12.9.1. Contractor shall provide to the Department or its agents any information or data relative to the Work. In such instances, and at the direction of the Department, Contractor shall fully cooperate

with such requests and furnish all data or information in a timely manner, in the format in which it is requested.

12.9.1.1. Contractor shall have at least 30 calendar days, or a timeframe mutually agreed upon between the Department and Contractor, to fulfill such requests.

12.9.1.2. Contractor shall certify that data and information it submits to the Department is accurate.

13. COMPLIANCE AND PROGRAM INTEGRITY

13.1. Program Integrity Compliance Program Requirements

13.1.1. Contractor shall have a program in place for ensuring compliance with the ACC program rules, Contract requirements, state and federal regulations and confidentiality regulations, and a program to detect Fraud, Waste and Program Abuse. Contractor shall ensure that all aspects of the ACC are focused on providing high-quality services that are of Medical Necessity in accordance with Contract requirements.

13.1.2. Contractor shall comply with all applicable CMS regulations in 42 CFR § 438.

13.1.3. Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims under 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.

13.1.4. The compliance program shall be approved by Contractor's Chief Program Officer and Compliance Officer.

13.1.5. Contractor shall ensure that the compliance program, at a minimum includes:

13.1.5.1. Written policies and procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements and standards under Exhibit M, and all applicable federal and state requirements.

13.1.5.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer or the board of directors.

13.1.5.3. The establishment of a Regulatory Compliance Committee on the Board of Directors or at the senior management level charged with overseeing Contractor's compliance program and its compliance with the requirements under the Contract.

13.1.5.4. A system for training and education for the Compliance Officer, Contractor's Key Personnel, and Contractor's employees for the federal and state standards and requirements under the Contract.

13.1.5.4.1. Contractor shall ensure that this training is conducted in a manner that allows the Department to verify that the training has occurred.

13.1.5.5. Effective lines of communication between the Compliance Officer and Contractor's employees.

13.1.5.6. Enforcement of standards through well publicized disciplinary guidelines.

13.1.5.7. Establishment and implementation of procedures and a program integrity infrastructure that includes, at least:

13.1.5.7.1. Adequate systems and staff for routine internal monitoring and auditing of compliance risks.

13.1.5.7.2. Prompt response to compliance issues as they are raised.

13.1.5.7.3. Annual audits of one percent or more of claims paid for potential Fraud, Waste, and Program Abuse.

13.1.5.7.4. Investigation of potential compliance problems as identified in the course of self-evaluation and audits.

13.1.5.7.5. 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.

13.1.5.8. Contractor shall ensure that the compliance program includes the following processes:

13.1.5.8.1. Screening all provider claims processed or paid by Contractor collectively and individually, for Suspected Fraud, Waste or Program Abuse.

13.1.5.8.2. Identifying Overpayments to Providers, including but not limited to, instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.

13.1.5.8.3. Recovering Overpayments to Providers.

13.1.5.8.4. Identifying and promptly reporting to the Department instances of Suspected Fraud, Waste and Program Abuse. Contractor shall search for Fraud, Waste, and Program Abuse by reviewing for Provider outliers in utilization and billing, and cross check with Member complaints.

13.1.5.8.5. Member verification of services. Specifically, to provide individual notices to all or a statistically significant sample of Members who received services to verify and report whether services billed by Providers were actually received by Members.

13.1.5.9. Contractor shall have a process for Network Providers to report and return Overpayments to Contractor, including, at least:

13.1.5.9.1. Requirements for Network Providers to report to Contractor when they have received an Overpayment.

13.1.5.9.2. To return the Overpayment to Contractor.

13.1.5.9.3. To notify Contractor in writing of the reason for the Overpayment within 60 calendar days after the date on which the Overpayment was identified.

13.1.5.10. Contractor shall supply the Department the information submitted by a Network Provider related to an identified Overpayment within 30 calendar days after receiving the same information.

13.1.5.10.1. Contractor may retain Overpayments returned by Network Providers when Contractor has met their MLR.

13.1.5.11. 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 Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in § 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

13.1.5.12. Contractor shall comply with the Department policies related to recoveries of Overpayments.

13.1.5.12.1. Contractor shall not retroactively recover Provider payments if:

13.1.5.12.1.1. A Member was initially determined to be eligible for medical benefits pursuant to section § 25.5-4-205, C.R.S. when the Provider has an eligibility guarantee number for the recipient, or:

13.1.5.12.1.2. Contractor makes an error processing the claim, but the claim is otherwise accurately submitted by the Provider.

13.1.5.12.2. Contractor shall not retroactively recover Provider payments after 12 months from the date a claim was paid, except in the following instances:

13.1.5.12.2.1. Medicare, commercial insurance, or third-party liability is the primary payer for a claim.

13.1.5.12.2.2. The claim is the subject of a state or federal audit, including audits contractually required by the Department.

13.1.5.12.2.3. The claim is subject to a law enforcement investigation.

13.1.5.12.2.4. The claim submitted was a duplicate.

13.1.5.12.2.5. The claim is fraudulent.

13.1.5.12.2.6. The Provider improperly billed the claim.

13.1.5.12.2.7. The claim was submitted with a billing code or diagnosis code that inaccurately or incorrectly resulted in reimbursement or bypassed prior authorization requirements.

13.1.5.12.3. If Contractor retroactively recovers a Provider payment that is equal to $1000.00 or more, Contractor shall work with the Provider to develop a payment plan if the provider requests a payment plan.

13.1.6. Contractor shall have a process for the prompt referral to the Department and the State Medicaid Fraud Control Unit (MFCU) of all cases where the agency or entity has actual and reasonable cause to believe that there is suspected Medicaid Fraud and Waste, Program Abuse and Patient Abuse, neglect, and exploitation, and false representation. The process shall be aligned with applicable requirements set forth in the General Provisions of this Contract, and applicable requirements in the Statement of Work and this section.

13.1.6.1. Neglect is the willful failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, including any neglect that constitutes a criminal violation under state law.

13.1.6.2. Exploitation includes any wrongful taking or use of funds or property of a patient residing in a health care facility or board and care facility that constitutes a criminal violation under state law.

13.1.6.3. False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a provider or Member who has actual knowledge of the truth or false nature of the statement, or by a provider or Member who has actual knowledge of the truth or false nature of the statement, or by a Provider or Member acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

13.2. Compliance Plan Requirements

13.2.1. Contractor shall have a documented Compliance Plan that implements all elements of the compliance program.

13.2.2. Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor Providers and Members to detect and prevent aberrant billing practices, potential Fraud, Waste, and Program Abuse, and promptly address potential compliance issues and problems.

13.2.3. Contractor shall ensure the Compliance Plan, at minimum, includes, all of the following:

13.2.3.1. A risk assessment of Contractor's various Fraud, Waste, and Program Abuse, and program integrity processes.

13.2.3.2. An outline of activities proposed for the next reporting year regarding, at least:

13.2.3.2.1. Compliance and audit activities, including, but not limited to:

13.2.3.2.1.1. Conducting prospective, concurrent, and/or post-payment reviews of claims, including, but not limited to:

13.2.3.2.1.1.1. Medical records reviews.

13.2.3.2.1.1.2. Data mining.

13.2.3.2.1.1.3. Desk audits.

13.2.3.2.1.2. Verifying Provider adherence to professional licensing and certification requirements.

13.2.3.2.1.3. Verifying Provider records and other documentation to ensure services billed by Providers were actually rendered.

13.2.3.2.1.4. Reviewing goods provided and services rendered for Fraud, Waste and Program Abuse.

13.2.3.2.1.5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).

13.2.3.2.2. Contractor shall not include activities related to administrative billing issues, such as financial statement audits.

13.2.3.2.3. Education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud, Waste, and Program Abuse to ensure that all of its officers, directors, managers, and employees know and understand the provisions of Contractor's Compliance Program and Compliance Plan.

13.2.3.2.4. Provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud, Waste, and Program Abuse and on identifying and educating targeted Providers with patterns of incorrect billing practices and/or Overpayments.

13.2.3.2.5. Cost avoidance measures taken to avoid improper payments from being made.

13.2.3.2.6. Descriptions of specific controls in place for prevention and detection of:

13.2.3.2.6.1. Overpayments and potential or Suspected Fraud, Waste, and Program Abuse, including but not limited to:

13.2.3.2.6.1.1. Automated pre-payment claims edits.

13.2.3.2.6.1.2. Desk audits on post-payment review of claims.

13.2.3.3. Work plans for the next year regarding conducting both announced and unannounced site visits and field audits to Network Providers to ensure services are rendered and billed correctly.

13.2.4. Contractor shall submit the Compliance Plan to the Department for review and approval. Contractor shall only submit finalized Compliance Plans to the Department for review and approval; the Department will not accept draft versions.

13.2.4.1. **DELIVERABLE:** Compliance Plan

13.2.4.2. **DUE:** May 15, 2025

13.2.5. Contractor shall review the Compliance Plan and make any necessary revisions for the following reporting year. Contractor shall submit revised Compliance Plans to the Department for review and approval.

13.2.5.1. **DELIVERABLE:** Compliance Plan documents and information

13.2.5.2. **DUE:** Annually, by July 31, starting in the second SFY

13.2.6. Contractor shall modify the Compliance Plan, as requested by the Department, within ten Business Days following the receipt of the Department's requested changes.

13.2.6.1. **DELIVERABLE:** Compliance Plan revisions and changes

13.2.6.2. **DUE:** Ten Business Days following the Department's request

13.3. Reports and Disclosures

13.3.1. Contractor shall follow all requirements in this Statement of Work Section 14.3 to notify the Department of all work, activities, and events occurring under the requirements of Statement of Work Section 14.1.

13.3.1.1. Reports Requiring Monthly Notification

13.3.1.1.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one-month period.

13.3.1.1.2. Contractor shall report, at minimum:

13.3.1.1.2.1. All identified or recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, and dates when Overpayments were recovered or a self-disclosure.

13.3.1.1.2.2. All suspended claim reimbursements and payments to a Provider, including information on whether the suspension is related to an audit or Fraud case, including the dates of when reimbursements and payments were suspended.

13.3.1.1.2.3. All Provider circumstance changes where a Provider is no longer in Contractor's network, but was not removed for cause, including providing information on why the Provider was withdrawn.

13.3.1.1.2.4. Any Provider terminations not based on quality or performance or for cause, including, but not limited to:

13.3.1.1.2.4.1. A change in ownership or control of a Provider.

13.3.1.1.2.4.2. A Provider voluntarily withdrawing from Contractor's network.

13.3.1.1.2.4.3. The death of a Provider.

13.3.1.1.2.4.4. In all cases of Provider termination, Contractor shall provide the following:

13.3.1.1.2.4.4.1. Date of removal.

13.3.1.1.2.4.4.2. Reason for the termination.

13.3.1.1.2.4.4.3. Numbers of Members served by the provider.

13.3.1.1.2.4.4.4. Plan to ensure that Members receive continuous services.

13.3.1.1.2.4.5. Any other information as specified by the Department.

13.3.1.1.3. Contractor shall deliver a Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report to the Department for review and approval.

13.3.1.1.3.1. **DELIVERABLE:** Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

13.3.1.1.3.2. **DUE:** Within ten Business Days after the end of each month

13.3.1.1.4. Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within 10 Business Days following the receipt of the Department's requested changes.

13.3.1.1.4.1. **DELIVERABLE:** Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

13.3.1.1.4.2. **DUE:** Within ten Business Days following the Department's request

13.3.1.2. Reports Requiring Semi-Annual Notification

13.3.1.2.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a six-month period.

13.3.1.2.2. The six-month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

13.3.1.2.3. Contractor shall submit the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report.

13.3.1.2.4. Contractor shall report and deliver, at minimum, all of the following:

13.3.1.2.4.1. A narrative outlining the compliance activities listed below and an explanation for any audits that were mentioned in the previous compliance plan that were not completed or any audits that were added after the compliance plan submission.

13.3.1.2.4.2. All audits or reviews which have been started, are on-going or completed as part of the compliance program and Compliance Plan, including, at least:

13.3.1.2.4.2.1. Issue(s) being reviewed or audited.

13.3.1.2.4.2.2. The status of the review or audit.

13.3.1.2.4.2.3. The start and end dates of services covered by the review or audit.

13.3.1.2.4.2.4. The start and end dates of the review or audit.

13.3.1.2.4.3. All instances of Suspected Fraud, Waste and Program Abuse, discovered and reported to the Department and the MFCU, including:

13.3.1.2.4.3.1. The suspected issue.

13.3.1.2.4.3.2. The start and end dates of the services suspected to involve Fraud.

13.3.1.2.4.3.3. The approximate amount of the claims affected and the date of report to the Department and the MFCU.

13.3.1.2.4.4. All verification conducted of Member services, including:

13.3.1.2.4.4.1. The number of notices sent to Members to verify and report whether services billed by providers were actually received by Members.

13.3.1.2.4.4.2. The number of responses received, number of responses warranting further action.

13.3.1.2.4.5. All identified or recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including:

13.3.1.2.4.5.1. Whether the Overpayment was related to an audit or Fraud case.

13.3.1.2.4.5.2. Dates of when Overpayments were identified.

13.3.1.2.4.5.3. Dates when Overpayments were recovered.

13.3.1.2.4.5.4. Any other information as specified by the Department.

13.3.1.2.5. Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

13.3.1.2.5.1. **DELIVERABLE:** Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

13.3.1.2.5.2. **DUE:** Within 45 days of the end after the six-month reporting period

13.3.1.2.6. Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

13.3.1.2.6.1. **DELIVERABLE:** Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

13.3.1.2.6.2. **DUE:** Within ten Business Days following the Department's request

13.3.1.3. Disclosures Requiring Prompt Notification

13.3.1.3.1. Provider Terminations and Disaffiliations

13.3.1.3.1.1. Contractor shall follow the process established by the Department to disaffiliate any PCMP from their network.

13.3.1.3.1.2. Contractor shall complete the disaffiliation no less than 10 Business Days prior to the end of the month.

13.3.1.3.1.3. Contractor shall notify the Department of any PCMP contract termination and disaffiliation no later than the 25th of every month.

13.3.1.3.1.4. Contractor shall notify the Department of the decision to terminate any existing Network Provider on the basis of quality or performance issues or for cause per 10 CCR 2505-10, § 8.076.1.7.

13.3.1.3.1.5. Contractor shall provide the following:

13.3.1.3.1.5.1. Provider's name and identification number.

13.3.1.3.1.5.2. Date of removal.

13.3.1.3.1.5.3. Number of Members served by the Provider.

13.3.1.3.1.5.4. Reason for the termination.

13.3.1.3.1.5.5. Narrative describing how Contractor intends to provide or arrange services for affected Members after the termination.

13.3.1.3.1.5.6. Any additional information as required by the Department.

13.3.1.3.1.5.6.1. **DELIVERABLE:** Notice of Network Provider Termination for Quality of Performance or For Cause

13.3.1.3.1.5.6.2. **DUE:** Within two Business Days after the decision to terminate for quality or performance issue terminations or terminations for cause

13.3.1.3.1.6. Contractor shall submit to the Department a list of all Network Providers that have been or will be disaffiliated or terminated from Contractor's network within the month.

13.3.1.3.1.6.1. **DELIVERABLE:** Notice of Network Provider Termination for Quality of Performance or For Cause

13.3.1.3.1.6.2. **DUE:** By the 25th day of the month in which a Network Provider has been or is scheduled to be disaffiliated or terminated from Contractor's network

13.3.1.3.2. Changes in Member Circumstances Affecting Eligibility

13.3.1.3.2.1. In accordance with 42 CFR § 438.608 (a)(3), Contractor shall promptly notify the Department when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including, but not limited to, all of the following:

13.3.1.3.2.1.1. Changes in the Member's residence.

13.3.1.3.2.1.2. The death of a Member.

13.3.1.3.2.2. Contractor shall submit the Provider/Member Change in Circumstance Disclosure.

13.3.1.3.2.3. Contractor shall provide, at minimum, all of the following:

13.3.1.3.2.3.1. The Member's name.

13.3.1.3.2.3.2. Medicaid ID number.

13.3.1.3.2.3.3. Date of change.

13.3.1.3.2.3.4. Description of the change.

13.3.1.3.2.3.5. Any additional information as required by the Department.

13.3.1.3.2.3.6. **DELIVERABLE:** Monthly Member Change in Circumstance Disclosure Report

13.3.1.3.2.3.7. **DUE:** Within ten Business Days after the end of each month

13.3.1.3.3. Overpayments

13.3.1.3.3.1. Contractor, or any Subcontractor delegated responsibility by Contractor for coverage of services and payment of claims under this contract, shall implement and maintain arrangements or procedures for prompt reporting within ten Business Days after all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to the Department.

13.3.1.3.3.1.1. **DELIVERABLE:** Notice of Overpayments Identified or Recovered

13.3.1.3.3.1.2. **DUE:** Within ten Business Days after identification or recovery of an overpayment

13.3.1.4. Disclosures Requiring Notification within 30 Days

13.3.1.4.1. Provider Licensure and Professional Review Actions

13.3.1.4.1.1. Contractor shall report all adverse licensure and professional review actions it has taken against any Provider, in accordance with 45 CFR Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank, to the Department, and to the appropriate state regulatory board. The following is a list of reportable actions:

13.3.1.4.1.1.1. Malpractice payments.

13.3.1.4.1.1.2. Licensure and certification actions.

13.3.1.4.1.1.3. Negative actions or findings.

13.3.1.4.1.1.4. Adverse actions.

13.3.1.4.1.1.5. Health Care-related criminal convictions.

13.3.1.4.1.1.6. Health Care-related civil judgments.

13.3.1.4.1.1.7. Exclusions from federal or state health care programs.

13.3.1.4.1.1.8. Other adjudicated actions of decisions.

13.3.1.4.1.1.8.1. **DELIVERABLE:** Notification of Adverse Licensure of Professional Review

13.3.1.4.1.1.8.2. **DUE:** Within 30 days following the date Contractor made an adverse licensure or professional review action

13.3.1.5. Disclosures Requiring Notification within 60 days

13.3.1.5.1. Overpayments and Excess Capitation Payments

13.3.1.5.1.1. Within 60 calendar days after identifying any Overpayments, per 42 CFR 438.608(d)(2), and any excess capitation payments, Contractor shall report and return an Overpayment to the Department.

13.3.1.5.1.2. Contractor shall provide the following:

13.3.1.5.1.2.1. Member information.

13.3.1.5.1.2.2. Claims information.

13.3.1.5.1.2.3. Encounter data information.

13.3.1.5.1.2.4. Paid amounts.

13.3.1.5.1.2.5. Provider information.

13.3.1.5.1.2.6. Dates of when Overpayment was identified and recovered.

13.3.1.5.1.2.7. Recovery amounts.

13.3.1.5.1.2.8. Capitation information.

13.3.1.5.1.2.9. Any other information as required by the Department.

13.3.1.5.1.3. Contractor shall use the Overpayment and Recovery Notification Disclosure template.

13.3.1.5.1.3.1. **DELIVERABLE:** Overpayment and Recovery Notification Disclosure

13.3.1.5.1.3.2. **DUE:** Within 60 calendar days after identifying excess capitation or other payments

13.4. Fraud, Waste, and Program Abuse

13.4.1. Contractor shall participate in routine meetings, held by the Department to discuss issues related to program integrity compliance activities and Fraud, Waste, and Program Abuse involving Medicaid funds and resources. The frequency of such meetings shall be at the sole discretion of the Department.

13.4.2. Contractor shall temporarily suspend all review activities or actions related to any Provider upon request of the Department.

13.4.3. Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

13.4.4. Contractor shall provide expert assistance to the Department, the Department's 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.

13.4.5. Contractor shall provide expert assistance that includes, at minimum, all of the following topics:

13.4.5.1. Any reports made pursuant to this section.

13.4.5.2. Any medical records review or Medical Necessity findings or determinations made pursuant to this Contract.

13.4.5.3. Provider treatment and business practices.

13.4.5.4. Provider billing practices and patterns.

13.4.6. Contractor shall meet with the Department, the Department's contractors or the MFCU to explain any reports or findings made pursuant to the section. Contractor shall cooperate with and provide assistance, including testimony, with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the program integrity section, the Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

13.4.7. Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when potential Fraud is suspected without the approval of the Department.

13.4.8. Contractor shall not take any action that might interfere with an investigation of possible Fraud by the Department, the MFCU, or any other law enforcement entity. Contractor shall assist the Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation.

13.4.9. Contractor shall temporarily suspend all review activities or actions related to any provider which Contractor suspects is involved in fraudulent activity. Contractor shall continue its investigation as requested by the Department.

13.5. Suspension of Payments Due to a Credible Allegation of Fraud

13.5.1. Contractor shall suspend payments due to a Credible Allegation of Fraud in full or in part only at the direction of the Department, in accordance with 42 CFR § 455.23.

13.5.2. Contractor shall release suspended payment amounts to the provider within one payment cycle when directed to do so by the Department.

13.5.3. Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

13.5.4. The Department may suspend payments to Contractor if Contractor is under investigation for a Credible Allegation of Fraud.

13.5.5. When Contractor has suspended payments to a provider due to a Credible Allegation of Fraud, Contractor shall create and provide to the Department a monthly report of payments which have been suspended.

13.5.5.1. **DELIVERABLE:** Suspended Payments Report

13.5.5.2. **DUE:** On the tenth Business Day of each month for the previous month where payments to a provider have been suspended due to a Credible Allegation of Fraud

13.6. Quality Improvement Inspection, Monitoring, and Site Reviews

13.6.1. Contractor shall enable and support the Department or its designee to conduct site reviews of Contractor's, Subcontractors' or Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in the Department's sole discretion to determine compliance with applicable Department regulations and the requirements of this Contract.

13.6.2. Site Reviews may include, but are not limited to:

13.6.2.1. Determining compliance with:

13.6.2.2. State and federal requirements.

13.6.2.3. Contracts.

13.6.2.4. Provider agreements.

13.6.2.5. Medicaid service provision and billing procedures.

13.6.2.6. Medicaid Bulletins and Provider Manuals.

13.6.3. Contractor shall cooperate with Department site review activities to monitor Contractor performance.

13.6.4. Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

13.6.5. 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.

13.6.6. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

13.6.7. For routine Site Reviews, Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted by the Department or its designee for mutually agreed upon dates for a Site Review.

13.6.7.1. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to Contractor at least three weeks prior to the visit.

13.6.7.1.1. 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.

13.6.7.2. Contractor has a minimum of 30 days to submit the required materials for non- emergency reviews.

13.6.8. Contractor shall make available, all records and documents related to the execution of this Contract, either on a scheduled basis, or immediately on an emergency basis, to the Department and its agents for Site Review.

13.6.8.1. Delays in the availability of such documents and records may subject Contractor to remedial actions. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.

13.6.9. The Department will transmit a written report of the Site Review to Contractor within 45 days after the Site Review. Contractor is allowed 30 days to review the preliminary report and respond to the findings. The final report will indicate, at least, areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

13.6.10. Contractor shall respond to any required actions identified by the Department or its designee, if necessary, with a corrective action plan within 30 days after the final written report, specifying the action to be taken to remedy any deficiencies noted by the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until Contractor is found to be in complete compliance. The Department will notify Contractor in writing when the corrective actions have been completed, accepted and Contractor is considered to be in compliance with Department regulations and Contract.

13.6.10.1. 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.

13.6.10.2. For corrective action plans affecting the provision of Covered Services to Members, Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

13.6.10.3. The Department will not accept any data submitted by Contractor to the Department or its agents after the last site visit day towards compliance with the visit in the written report. The Department will only apply this data toward the corrective action plan.

13.6.11. Contractor shall understand that the Site Review may include reviews of a sample of Network Providers to ensure that Network Providers have been educated and monitored by Contractor about the requirements under this Contract.

13.6.12. If the Site Reviewers wish to inspect a Network Provider location, Contractor shall ensure the following:

13.6.12.1. Network Providers make staff available to assist in the audit or inspection effort.

13.6.12.2. Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

13.7. Prohibitions

13.7.1. Contractor shall comply with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment. Contractor shall not pay a Network Provider for Provider-preventable conditions, as identified in the State Plan and 42 CFR § 438(g). Contractor shall ensure that Network Providers identify Provider- preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

13.7.1.1. Contractor shall deliver the Provider Preventable Conditions Report that includes all provider-preventable conditions. Contractor shall submit this report to the Department on an annual basis.

13.7.1.1.1. **DELIVERABLE:** Provider Preventable Conditions Report

13.7.1.1.2. **DUE:** Annually, by July 31

13.7.2. Contractor shall ensure all Network Providers are enrolled with the Department as Medicaid Providers, consistent with Provider disclosure, screening, and enrollment requirements, and no payment is made to a Network Provider pursuant to this Contract if a Network Provider is not enrolled with the Department as Medicaid Provider. This provision does not require the Network Provider to render services to Fee-for-Service beneficiaries.

13.7.3. The Department will not make payment to Contractor, if Contractor is:

13.7.3.1. An entity that could be excluded from under § 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

13.7.3.2. 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 § 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 §§ 1128 or 1128A of the Social Security Act.

13.7.3.3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

13.7.3.3.1. Any individual or entity excluded from participation in federal health care programs.

13.7.3.3.2. Any individual or entity that would provide those services through an excluded individual or entity.

13.7.3.4. Contractor shall not pay a Provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

13.7.3.4.1. The Provider or Subcontractor is excluded from participation in federal health care programs.

13.7.3.4.2. The Provider or Subcontractor has a relationship described in the section on prohibited affiliations.

13.7.4. Prohibited Affiliations

13.7.4.1. Contractor is prohibited from having a relationship with an individual or entity that is excluded from participation in any federal health care program as described in §§ 1128 and 1128A of the Social Security Act.

13.7.4.2. Contractor shall not knowingly have a relationship with:

13.7.4.2.1. 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 CFR § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.7.4.2.2. 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 CFR § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.7.4.2.3. A person with ownership or more than five percent of Contractor's equity who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 CFR § 2.101 or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.7.4.2.4. 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 CFR § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.7.4.2.5. 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 CFR § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.7.4.3. Contractor shall provide written disclosure to the Department of any prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, as defined in 438.608(c)(1).

13.7.4.4. If the Department learns 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:

13.7.4.4.1. Must notify the Secretary of the Department of Health and Human Services (Secretary) of the noncompliance.

13.7.4.4.2. May continue an existing agreement with Contractor unless the Secretary directs otherwise.

13.7.4.4.3. May not renew or extend the existing agreement with Contractor unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

13.7.5. Prohibited Payments

13.7.5.1. Contractor shall not make payments:

13.7.5.1.1. For an item or service, other than an emergency item or service, not including items or services furnished in an emergency room of a hospital, furnished:

13.7.5.1.1.1. Under the Contract by an individual or entity during any time period when the individual or entity is excluded from participation under title V, XVII, or XX or under title XIX pursuant to §§ 1128, 1128A, 1156, or 1842(j)(2);

13.7.5.1.1.2. At the medical direction or on the prescription of a physician, during the period when the physician is excluded from participation under title V, XVIII, or XX or under title XIX pursuant to §§ 1128, 1128A, 1156, or 1842(j)(2), and when the person furnishing such item or service knew, or had reason to know, of the exclusion; or

13.7.5.1.1.3. 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.

13.7.5.1.2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

13.7.5.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

13.7.5.1.4. 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.

13.8. General Compliance and Program Integrity Requirements

13.8.1. Business Transaction Disclosures

13.8.1.1. Contractor shall submit full and complete information about:

13.8.1.1.1. The ownership of any Subcontractor with whom Contractor has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request; and

13.8.1.1.2. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any Subcontractor, during the 5- year period ending on the date of the request.

13.8.1.2. **DELIVERABLE:** Disclosure of Business Transactions

13.8.1.3. **DUE:** Within 35 days following a request by the Department or by the Secretary of the Department of Health and Human Services.

13.8.2. Ownership or Control Disclosures

13.8.2.1. Contractor shall disclose to the Department information regarding ownership or control interests in Contractor at the time of submitting a provider application, at the time of executing the Contract with the State, at Contract renewal or extension, and within 35 days after either a change of ownership or a written request by the Department.

13.8.2.2. Contractor shall deliver the following ownership and control disclosure information in a form to be provided by the Department:

13.8.2.2.1. The name, title and address of any individual or entity with an ownership or control interest in Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

13.8.2.2.2. Date of birth and Social Security Number of any individual with an ownership or control interest in Contractor.

13.8.2.2.3. Tax identification number of any corporation or partnership with an ownership or control interest in Contractor, or in any Subcontractor in which Contractor has a 5% or more interest.

13.8.2.2.4. Whether an individual with an ownership or control interest in Contractor is related to another person with an ownership or control interest in Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any Subcontractor in which Contractor has a five percent or more interest is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling.

13.8.2.2.5. The name of any other Provider (other than an individual practitioner or Group of Practitioners), Fiscal Agent, or MCE in which an owner of Contractor has an ownership or control interest.

13.8.2.2.6. The name, title, address, date of birth, and Social Security Number of any Managing Employee of Contractor.

13.8.2.2.6.1. **DELIVERABLE:** Ownership or Control Disclosures

13.8.2.2.6.2. **DUE:** Annually on July 31, and within 35 days after either a change of ownership or a written request by the Department.

13.8.3. Conflict of Interest

13.8.3.1. Contractor shall comply with the conflict of interest provisions outlined in Section 9, Conflict of Interest in the Contract Provisions along with all requirements in this Section.

13.8.3.2. Contractor shall comply with the conflict of interest safeguards described in 42 CFR §438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

13.8.3.3. The term "conflict of interest" means that:

13.8.3.3.1. Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

13.8.3.3.2. 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.

13.8.3.3.3. A conflict of interest exists even if Contractor does not use information obtained from one party in Contractor's dealings with the other.

13.8.3.4. Contractor shall deliver a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest.

13.8.3.4.1. **DELIVERABLE:** Conflict of Interest Disclosure Statement

13.8.3.4.2. **DUE:** Within ten Business Days after Contractor learns of an existing appearance of a conflict of interest situation

13.8.3.5. As required by § 25.5-5-402, C.R.S, Contractor may be required to submit quarterly data about rates paid to Providers in Contractor's network. If required to do so, Contractor shall submit required rate information on a template provided by the Department on the last day of each State fiscal quarter.

13.8.3.5.1. **DELIVERABLE:** Supplemental Conflict of Interest Data

13.8.3.5.2. **DUE:** Quarterly, on the last day of each State fiscal quarter

13.8.4. Subcontracts and Contracts

13.8.4.1. Contractor shall disclose to the Department copies of any existing subcontracts and contracts with Providers upon request.

13.8.4.2. Contractor shall ensure that no Member is billed by a Subcontractor or provider for any amount greater than would be owed if Contractor provided the services directly or in violation of § 25.5-4-301(1)(a)(I), (II) and (II.5), C.R.S.

13.8.4.2.1. **DELIVERABLE:** Subcontracts and Provider Contracts

13.8.4.2.2. **DUE:** Within five Business Days after the Department's Request

13.8.5. Screening of Employees and Contractors

13.8.5.1. Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the Department of Health and Human Services Office of the Inspector General (HHS-OIG).

13.8.5.2. Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of Contractor's employees and Subcontractors against the HHS-OIG's List of Excluded Individuals to determine whether each employee or Subcontractor has been excluded from participation in Medicaid.

13.8.5.3. If Contractor determines that one of Contractor's employees or Subcontractors has been excluded, then Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery to the Department.

13.8.5.3.1. **DELIVERABLE:** Notification of Discovery of Excluded Employee or Subcontractor

13.8.5.3.2. **DUE:** Within five Business Days after discovery

13.8.6. Disclosure of Information on Persons Convicted of Crimes

13.8.6.1. Upon submitting a Provider application, upon execution of the Contract, upon renewal or extension of the Contract, and within 35 days after the date of a written request by the Department, Contractor shall disclose the identity of any person who:

13.8.6.1.1. Has an ownership or control interest in Contractor, or who is a managing employee of Contractor; and

13.8.6.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX services program, or Title XXI of the Social Security Act.

13.8.6.1.2.1. **DELIVERABLE:** Disclosure of Information on Persons Convicted of Crimes

13.8.6.1.2.2. **DUE:** Within 35 days after either a change of ownership or a written request by the Department.

13.8.7. Security Breaches and HIPAA Violations

13.8.7.1. In the event of a breach of the security of sensitive data, Contractor shall immediately notify the Department of all suspected loss or compromise of sensitive data within five Business Days after the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

13.8.7.2. Contractor shall comply with the requirements of § 6-1-716, C.R.S, and any other applicable state and federal laws and regulations.

13.8.7.3. Contractor shall report all HIPAA violations as described in the HIPAA Business Associates Addendum.

13.8.7.3.1. **DELIVERABLE:** Security and HIPAA Violation Breach Notification

13.8.7.3.2. **DUE:** Within five Business Days after Contractor becomes aware of the breach

13.8.8. Maintenance of Records

13.8.8.1. Contractor shall ensure that all of Contractor's Subcontractors and Providers comply with all record maintenance requirements of the Contract including Contract provisions outlined in Section 7 Contractor Records, of the Contract Provisions.

13.8.8.2. Notwithstanding any other requirement of the Contract, Contractor shall retain and require Subcontractors to retain, as applicable, Member Grievance and Appeal records in accordance with 42 CFR § 438.416, base data in accordance with 42 CFR § 438.5(c), MLR reports in accordance with 42 CFR § 438.8(k), and the data, information, and documentation specified is 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten years.

13.8.9. Inspection and Audits

13.8.9.1. In addition to the record-keeping and audit provisions outlined in Section 7, Contractor Records in the Contract Provisions, Contractor shall comply with the documentation, retention, and access requirements detailed in this Section.

13.8.9.2. Contractor shall allow the Department, CMS, HHS-OIG, the Comptroller General, and any of their designees to inspect and audit any records or documents of Contractor or Contractor's Subcontractors and shall allow the Department, CMS, HHS-OIG, the Comptroller General, and any of their designees to, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

13.8.9.3. Contractor shall cooperate with federal evaluators and make any data available for the federal evaluation, as is required under 42 CFR § 431.420(f) to support federal evaluation.

13.8.9.4. Notwithstanding any other provision in the Contract, Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General, and any of their designees this authority to inspect and audit Contractor's records and documents for ten years from the final date the Contract is active or from the date of completion of any audit, whichever is later.

13.8.9.5. Contractor shall allow CMS or CMS's agent or designated contractor and the Department or the Department's agent to conduct unannounced, on-site inspections for any reason.

13.8.9.6. In the event that right of access is requested, Contractor and/or Contractor's Subcontractors or providers shall:

13.8.9.6.1. Make staff available to assist in any audit or inspection under the Contract.

13.8.9.6.2. Provide adequate space on the premises to reasonably accommodate

13.8.9.6.3. Department, state, or federal or any of their designees' personnel conducting all audits, Site Reviews, or inspections.

13.8.9.6.4. 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 Contractor or Contractor's Subcontractors pertaining to the ability of Contractor or Contractor's subcontractor's ability to bear the risk of financial losses.

13.8.9.6.5. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of Contractor's, Subcontractor's or Providers' provision of care.

13.8.9.6.6. Contractor shall allow access to Contractor's claims system and claims data by Department staff for program integrity activities.

13.8.9.6.7. In consultation with the Department, Contractor shall participate in compliance monitoring activities and respond to any Department or Department's designee's 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.

13.8.9.7. Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five Business Days.

13.8.9.8. Contractor shall have staff available to assist in any audit or inspection under the Contract.

13.9. Financial Reporting

13.9.1. To achieve the ACC's objective of greater accountability and transparency, Contractor shall participate in a robust financial reporting program.

13.9.2. In addition to the conflict of interest provisions outlined in Section 9, Conflict of Interest, the Contractor shall comply with the disclosure and affiliation restrictions in this Section.

13.9.3. Contractor shall submit financial information to the Department on both a quarterly and annual basis, and attend in-person quarterly meetings to review and discuss Contractor's financial information as follows:

13.9.3.1. Contractor shall quarterly compile financial information that shall include, but not be limited to, all of the following:

13.9.3.1.1. Quarterly internal financial statements, including balance sheet and income statement.

13.9.3.1.2. Quarterly trial balance listing all account numbers, descriptions, and amounts.

13.9.3.1.3. Crosswalk and/or allocation schedule(s) to link the quarterly trial balance to the quarterly financial report.

13.9.3.1.4. Quarterly financial report using a template that has been agreed upon by Contractor and the Department. The report shall contain a detailed accounting of the total revenue received from the Department during the quarter and how payments were spent, including but not limited to, the following information:

13.9.3.1.4.1. The amount and percentage of payments Contractor spent during the reporting period to support the following categories of work:

13.9.3.1.4.1.1. PCMP Network Provider support, with a break-down of administrative payments made to PCMPs based on the payment strategy used (PMPM or other payment arrangement).

13.9.3.1.4.1.2. Care Coordination, with a breakdown of dollars Contractor spent on contracted Care Coordination and Care Coordination provided by Contractor.

13.9.3.1.4.1.3. Practice support to include specific information about the types of practices supported.

13.9.3.1.4.1.4. Administration.

13.9.3.1.4.1.5. Network development.

13.9.3.1.4.1.6. Community infrastructure and Health Neighborhood participants.

13.9.3.1.4.1.7. Systems support and capital infrastructure investments.

13.9.3.1.4.1.8. Subcontractors.

13.9.3.1.4.1.9. The categories listed above may be expanded as a result of the process of developing the reporting template.

13.9.3.1.4.1.10. Incurred but not reported reserves, defined as the financial reserves held by Contractor to cover services or claims that have been incurred but not reported as of the evaluation date.

13.9.3.2. Contractor shall deliver the Quarterly Financial Information to the Department for review and approval.

13.9.3.2.1. **DELIVERABLE:** Quarterly Financial Information

13.9.3.2.2. **DUE:** No later than 45 days from the end of the State Fiscal quarter

13.9.4. Contractor shall compile an Audited Annual Financial Statement that includes, at a minimum, all of the following:

13.9.4.1. Annual internal financial statements, including balance sheet and income statement.

13.9.4.2. Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP). The audited annual financial statements must be certified by an independent public accountant and Contractor's Chief Financial Officer or their designee.

13.9.5. Contractor shall submit the Audited Annual Financial Statement to the Department.

13.9.5.1. **DELIVERABLE:** Audited Annual Financial Statement

13.9.5.2. **DUE:** No later than six months after the end of the SFY that the statement covers

13.9.6. Contractor shall participate in quarterly meetings with the Department to formally present and review the quarterly financial reports submitted to the Department. These meetings will be held by the Department not more than 30 days after the submission of the report. Contractor shall ensure that the Chief Program Officer and Chief Financial Officer (CFO) are in attendance at these meetings.

13.9.7. Contractor shall submit other financial reports and information as requested by the Department or the Department's designee.

13.9.8. 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:

13.9.8.1. Fact-checking.

13.9.8.2. Auditing reported data.

13.9.8.3. Performing site visits.

13.9.8.4. Requesting additional information.

13.9.9. If the Department determines that there are errors or omissions in any reported information, Contractor shall deliver an updated report that corrects all errors and includes all omitted data or information. Contractor shall deliver the updated report to the Department within ten days from the Department's request for the updated report.

13.9.9.1. **DELIVERABLE:** Updated Financial Reports or Statements

13.9.9.2. **DUE:** Ten days after the Department's request for the updated report or statement

13.9.10. On a quarterly basis, Contractor shall provide information to demonstrate that it has sufficient terminal liability reserves for the purpose of financing claims incurred but not yet paid as well as related administration expenses to close down the plan in the event of Contractor's Medicaid plan dissolution or termination for any reason. For the purpose of this provision, a demonstration of sufficient terminal liability reserves means that Contractor provides financial

information as required by the Department that shows compliance with the following: (a) Contractor reserves required under this section are sufficient to meet its outstanding claims liability under this contract as of the date of the report, (b) Contractor complies with the intent of Colorado Division of Insurance's statutory requirements at C.R.S. 10-16-411(1.5)(a)(I-II) even if Contractor is licensed to take financial risk under this contract in a structure other than an HMO, (c) Contractor has funding and resources that are at least equal to one month of capitated payments received by Contractor for services provided under this Contract.

13.10. Graduate Medical Education (GME) Hospital Report

13.10.1. Contractor shall submit GME data quarterly according to the specifications provided by the Department. Contractor shall certify all data submitted is accurate, complete, and truthful based on the Contractor's best knowledge, information, and belief. Contractor shall ensure that this certification is signed by either Contractor's Chief Program Officer or Chief Financial Officer (CFO) or by an individual who has delegated authority to sign for, and who reports directly to, Contractor's Chief Program Officer or CFO.

13.10.1.1. **DELIVERABLE:** GME Report

13.10.1.2. **DUE:** Quarterly on July 31, October 31, January 31, and April 30.

13.11. Solvency

13.11.1. Contractor shall notify the Department, upon becoming aware of or having reason to believe that Contractor does not, or may not, meet the solvency standards, established by the State for health maintenance organizations.

13.11.2. Contractor shall not hold liable any Member for Contractor's debts, in the event Contractor becomes insolvent.

13.11.3. Contractor shall not hold liable any Member for Covered Services provided to the Member, for which the Department does not pay Contractor, or for which the Department or Contractor does not pay the Provider that furnished the service under a contractual, referral, or other arrangement.

13.11.4. Contractor shall not hold liable any Member for Covered Services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor covered the services directly.

13.11.5. Contractor shall provide assurances satisfactory to the Department that Contractor's provision against the risk of insolvency is adequate to ensure that Members will not be liable for Contractor's debt, in the event Contractor becomes insolvent.

13.11.5.1. **DELIVERABLE:** Solvency Notification

13.11.5.2. **DUE:** Within two Business Days after Contractor becomes aware of a possible solvency issue.

13.12. Warranties and Certifications

13.12.1. Contractor shall disclose to the Department if Contractor is no longer able to provide the same warranties and certifications described in Section 1 as required at the Effective Date of the Contract.

13.13. Actions Involving Licenses, Certifications, Approvals, and Permits

13.13.1. Provider Insurance

13.13.1.1. Contractor shall ensure that Network Providers comply with all applicable local, state, and federal insurance requirements necessary in the performance of this contract. Minimum insurance requirements shall include, but are not limited to, all the following:

13.13.1.1.1. Physicians participating in Contractor's plan shall be insured for malpractice, in an amount equal to a minimum of $500,000.00 per incident and $1,500,000.00 in aggregate per year.

13.13.1.1.2. Facilities participating in Contractor's plan shall be insured for malpractice, in an amount equal to a minimum of $500,000.00 per incident and $3,000,000.00 in aggregate per year.

13.13.1.1.3. Sections 13.15.1.1.1 and 13.15.1.1.2 shall not apply to Physicians and facilities in Contractor's network which meet any of the following requirements:

13.13.1.1.3.1. The Physician or facility is a public entity or employee pursuant to § 24-10- 103, C.R.S. of the Colorado Governmental Immunity Act, as amended.

13.13.1.1.3.2. The Physician or facility maintains any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to § 13-64-301, C.R.S., as amended.

13.13.1.1.4. Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, Contractor shall notify the Department of such cancellation within two Business Days of when the coverage is cancelled.

13.13.1.2. Contractor shall notify the Department of:

13.13.1.2.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of § 10, 16, -401, et seq., C.R.S. as a Health Maintenance Organization.

13.13.1.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

13.13.1.2.3. Any revocation, withdrawal, or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

13.13.1.2.3.1. **DELIVERABLE:** Notification of Actions Involving Licenses, Certifications, Approvals and Permits

13.13.1.2.3.2. **DUE:** Within two Business Days after Contractor's notification from Colorado Commissioner of Insurance

13.14. Federal Intermediate Sanctions

13.14.1. The Department may implement any intermediate sanctions, as described in 42 CFR § 438.702, if Contractor:

13.14.1.1. Fails substantially to provide Medically Necessary services that Contractor is required to provide, under law or under this Contract with the Department, to a Member covered under the Contract.

13.14.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

13.14.1.3. Acts to discriminate among Members on the basis of a Member's health status or need for health care services.

13.14.1.4. Misrepresents or falsifies information that Contractor furnishes to CMS or to the Department.

13.14.1.5. Misrepresents or falsifies information that Contractor furnishes to a Member, potential Member, or health care provider.

13.14.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210.

13.14.1.7. Has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

13.14.1.8. Has violated any of the other applicable requirements of §§ 1903(m), 1932, or 1905(t) of the Social Security Act and any implementing regulations.

13.14.2. Notice of Sanction and Pre-Termination Hearing

13.14.2.1. Before imposing any of the intermediate sanctions specified in this Section 13.14.2, the Department must give Contractor timely written notice that explains the basis and nature of the sanction, and any other due process protections that the Department elects to provide.

13.14.2.2. In addition to the remedies and enforcement provisions outlined in Section 12 Remedies of the Contract Provisions, Contractor shall be subject to the sanction and pre-termination hearing requirements set forth in this Section. Before terminating any contracts with Contractor, the Department must provide Contractor a pre-termination hearing.

13.14.2.3. Prior to a pre-termination hearing, the Department must provide Contractor with the following:

13.14.2.3.1. Written notice of the Department's intent to terminate, the reason for termination, and the time and place of the hearing.

13.14.2.3.2. After the hearing, the Department must provide Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination of the Contract.

13.14.2.3.3. For an affirming decision, give Members of Contractor notice of the termination and information on the Members' options for receiving Medicaid services following the effective date of termination of the Contract.

13.14.3. Payments provided for under the Contract shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 CFR § 438.730.

13.15. Termination Under Federal Regulations

13.15.1. In addition to the termination and enforcement provisions outlined in Section 12 Remedies of the Contract Provisions, the Department may terminate this Contract for cause in accordance with

the requirements set forth in this section and applicable federal regulations and enroll any Member enrolled with Contractor in another plan, or provide Member's benefits through other options included in the State Plan, if the Department determines that Contractor has failed to:

13.15.1.1. Carry out the substantive terms of its contracts.

13.15.1.2. Meet applicable requirements in §§ 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

13.15.2. Before terminating Contractor's Contract as described in this Section 13.15, the Department shall:

13.15.2.1. Provide Contractor a cure notice that includes, at a minimum, all of the following:

13.15.2.1.1. The Department's intent to terminate.

13.15.2.1.2. The reason for the termination.

13.15.2.1.3. The time and place for the pre-termination hearing.

13.15.2.2. Conduct a pre-termination hearing.

13.15.2.3. Give Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

13.15.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to Contractor that contains the effective date of the termination of the Contract.

13.15.2.4.1. Upon receipt of the termination notice, Contractor shall give Members enrolled with Contractor notice of the termination and information, consistent with 42 CFR § 438.10, on Members' options for receiving Medicaid services following the effective date of termination.

13.15.3. Once the Department has notified Contractor of the Department's intent to terminate under this section, the Department may give Members enrolled with Contractor written notice of the Department's intent to terminate the Contract.

13.15.4. The Department may choose to impose any of the following intermediate sanctions if Contractor violates any applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and its implementing regulations:

13.15.4.1. Allow Members enrolled with Contractor to Disenroll immediately, without cause.

13.15.4.2. Suspend all new enrollments to Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act.

13.15.4.3. Suspend payments for all new enrollments to Contractor's managed care capitation initiative until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

13.15.5. Should any part of Exhibit M relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust capitation rates

to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the Department paid Contractor in advance to work on a no-longer- authorized program or activity and under the terms of this contract, the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in the Department's payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

14. COMPENSATION

14.1. Summary of Compensation to Contractor

14.1.1. Compensation to Contractor will consist of the following:

14.1.1.1. An actuarially certified monthly Capitated Payment, as specified in Exhibit C, for each active Member assigned to Contractor on the first day of the month and for Members whose enrollment starts from the 2nd through the 17th of the month. The Department will set the monthly Capitated Payment rate at the actuarially certified point estimate in accordance with 42 CFR § 438.

14.2. Process for Capitated Payment

14.2.1. The Department will calculate the number of active Members enrolled with Contractor's MCO based on the enrollment information in interChange.

14.2.2. The Department will remit all Capitated Payments through interChange via electronic funds transfer to a bank account designated by Contractor. The Department will provide Contractor with a monthly payment report through interChange.

14.2.2.1. Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

14.2.3. The Department will remit all Capitated Payments to Contractor within the month for which the payment applies.

14.2.3.1. In the event that Contractor is not compensated for a Member in a month for which Contractor should have been compensated, the Department will compensate Contractor for that Member retroactively.

14.3. Special Provisions for Monthly Capitated Payment

14.3.1. The monthly Capitated Payment shall be considered payment in full for all Covered Services set forth in Section 10.

14.3.2. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Section 10 and any other provision of the Contract, Section 10 shall prevail over other provisions of this Contract.

14.3.3. Actions Impacting Existing Rates

14.3.3.1. Contractor shall inform the Department prior to making changes to rate payment methodologies, provider recoupments, or other financial adjustments that may impact the underlying assumptions the rate is built on.

14.4. The Department will reimburse Contractor for Specialty Drugs according to the terms in this section.

14.4.1. The Department will reimburse Contractor in accordance with the deductions stated below after the drug cost of the Specialty Drugs exceeds $100,000.00 per treated Member.

14.4.2. The Department will reimburse Contractor in accordance with the deductions stated below after the drug cost of the Specialty Drugs exceeds $100,000.00 per treated Member.

14.4.3. No payments to Contractor for Specialty Drugs will exceed Department reimbursement levels set forth in the Department's approved State Plan with CMS.

14.4.4. The Department will reimburse Contractor for the invoice cost of the drugs, after all the following have been deducted:

14.4.4.1. Any discounts available to the requesting Provider pursuant to the federal 340B drug program.

14.4.4.2. Any rebates available to the requesting provider through the federal Medicaid Drug Rebate Program.

14.4.4.3. 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. 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.

14.4.5. 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:

14.4.5.1. The calculated trended historical cost embedded in capitation rate, associated with the treated Member, or the diagnoses and other codes related treatment.

14.4.5.2. The calculated trended historical cost embedded in capitation rate, associated with the treated Member, or the diagnoses and other codes related treatment.

14.4.5.3. The cost in the current State Fiscal year associated with the treated Member, or the diagnoses and other codes related treatment, excluding Specialty Drugs.

14.4.6. The Department will pay Contractor for Specialty Drugs quarterly within 60 days of the end of the quarter or the receipt of appropriate documentation, whichever is later.

14.4.7. The Department, with assistance from its contracted actuary, will decide to include prospective risk-based coverage for Specialty Drugs when sufficient cost and utilization experience accumulates within the base data available for the calculation of actuarially sound rates. The Department will communicate the inclusion with Contractor.

14.4.8. The Department, with assistance from its contracted actuary, will decide to include prospective risk-based coverage for Specialty Drugs when sufficient cost and utilization experience accumulates within the base data available for the calculation of actuarially sound rates. The Department will communicate the inclusion with Contractor. The Department will determine drug selection, substitution effect calculation, and payment reconciliation.

14.5. Payment Calculation Disputes

14.5.1. In the event that Contractor believes that the calculation or determination of any payment is incorrect, Contractor shall notify the Department of its dispute within 30 days following the receipt of the payment calculation or determination. 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.

14.6. Recoupments

14.6.1. The Department shall recoup monthly Capitated Payment amounts paid to Contractor in error. Error may be either human or machine error on the part of the Department, Contractor, or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, change in MCO or PCMP enrollment due to a Member choosing to disenroll, or situations where the Member cannot use Contractor's facilities.

14.6.2. Contractor shall refund to the Department any overpayments due the Department within 30 days after discovering the overpayments or being notified by the Department that overpayments are due. If Contractor fails to refund the overpayments within 30 days, the Department shall deduct the overpayments from the next payment to Contractor.

14.6.3. Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within 90 days after termination of the Contract.

14.6.4. Payments made by the Department to Contractor due to Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

14.6.5. Where Membership is disputed between two Contractors, the Department shall be final arbitrator of Membership and shall recoup any Capitated Payments.

14.6.6. Contractor's obligation to refund all calculated rebates continues subsequent to the termination of the Contract.

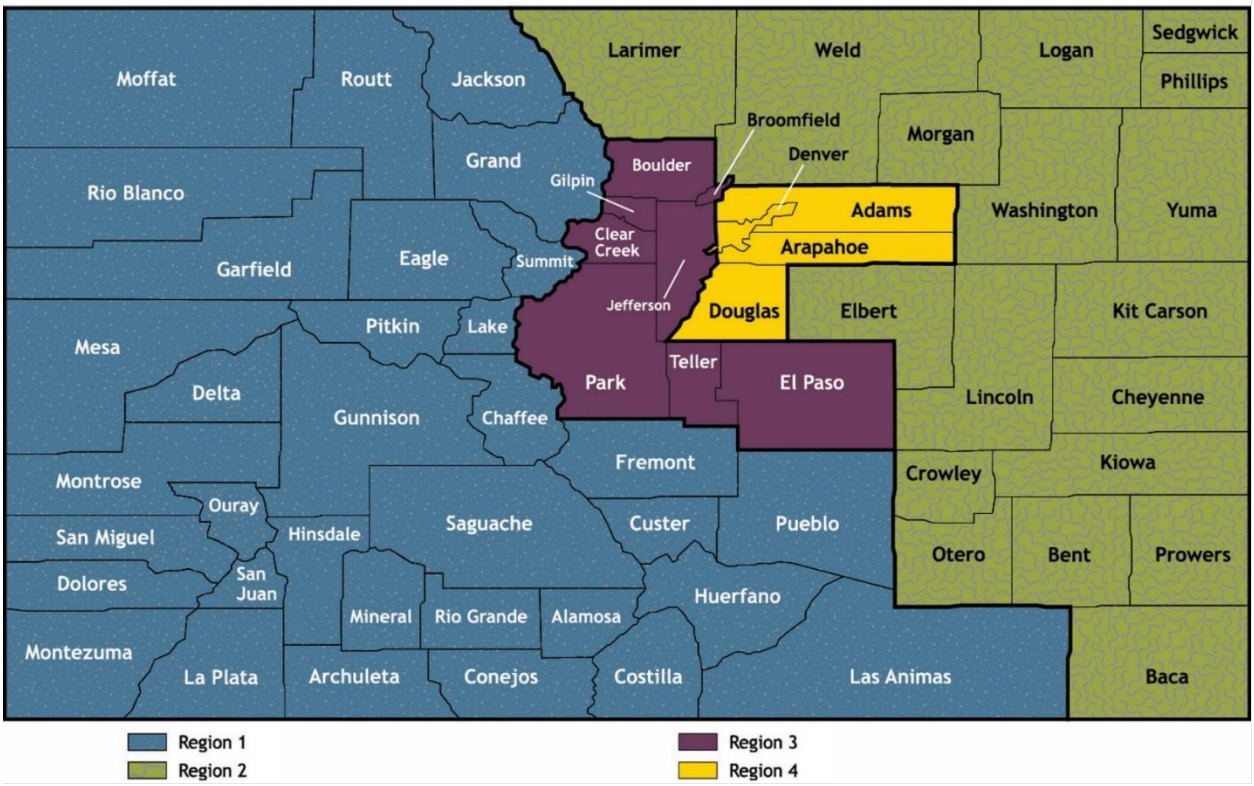
14.7. Compensation

14.7.1. Contractor will receive payment as specified in this Exhibit M.

14.8. Closeout Payments

14.8.1. Notwithstanding anything to the contrary in this Contract, all payments for the final month of this Contract shall be paid to Contractor no sooner than 10 days after the Department has determined that Contractor has completed all of the requirements of the Closeout Period.

EXHIBIT N, MAP OF REGIONS AND ASSOCIATED COUNTIES



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COUNTIES	MMIS COUNTY CODE
REGION 1	
1. ALAMOSA	2
2. ARCHULETA	4
3. CHAFFEE	8
4. CONEJOS	11
5. COSTILLA	12
6. CUSTER	14
7. DELTA	15
8. DOLORES	17
9. EAGLE	19
10. FREMONT	22
11. GARFIELD	23
12. GRAND	25
13. GUNNISON	26
14. HINSDALE	27
15. HUERFANO	28
16. JACKSON	29
17. LA PLATA	34
18. LAKE	33
19. LAS ANIMAS	36
20. MESA	39
21. MINERAL	40
22. MOFFAT	41
23. MONTEZUMA	42
24. MONTROSE	43
25. OURAY	46
26. PITKIN	49
27. PUEBLO	51
28. RIO BLANCO	52
29. RIO GRANDE	53
30. ROUTT	54
31. SAGUACHE	55
32. SAN JUAN	56
33. SAN MIGUEL	57
34. SUMMIT	59
REGION 2	
1. BACA	5
2. BENT	6
3. CHEYENNE	9
4. CROWLEY	13
5. ELBERT	20

COUNTIES	MMIS COUNTY CODE
6. KIOWA	31
7. KIT CARSON	32
8. LARIMER	35
9. LINCOLN	37
10. LOGAN	38
11. MORGAN	44
12. OTERO	45
13. PHILLIPS	48
14. PROWERS	50
15. SEDGWICK	58
16. WASHINGTON	61
17. WELD	62
18.YUMA	63
REGION 3	
1. BOULDER	7
2. BROOMFIELD	80
3. CLEAR CREEK	10
4. EL PASO	21
5. GILPIN	24
6. JEFFERSON	30
7. PARK	47
8. TELLER	60
REGION 4	
1. ADAMS	1
2. ARAPAHOE	3
3. DENVER	16
4. DOUGLAS	18

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EXHIBIT O-1, HB21-1289 IMPLEMENTATION

1. PROJECT REQUIREMENTS

1.1. Contractor shall expand Work to the following populations as covered Members, in compliance with C.R.S. 25.5-8-109(6)(a), and C.R.S. 25.5-8-109(7)(a):

1.1.1. Pregnant or postpartum individuals up to 12 months after the pregnancy ends who otherwise would not have been eligible for Medicaid due solely to the individual's immigration or citizenship status.

1.1.2. Children who are less than nineteen years of age who otherwise would not have been eligible for Medicaid due solely to the child's immigration or citizenship status.

1.2. Contractor shall align Work provided to these populations with Work provided to all other Members.

1.3. Contractor shall not discriminate against any Member based on immigration or citizenship status for the implementation of Work.

2. FUNDING REQUIREMENTS

2.1. Contractor shall ensure that project funds are tracked distinctly from other funds and are not mixed with any federal funding.

2.2. Contractor shall submit financial reporting specific to these populations to the Department in a format and frequency determined by the Department.

3. PRIVACY

3.1. Contractor shall use the minimum data necessary to protect the personal health information and enrollment status in the program for Members covered and engaged by Contractor with the Work under these categories.

4. DELIVERABLES

4.1. Contractor shall report on Members covered under these categories in an existing Deliverable in a format and frequency determined by the Department.

5. RISK CORRIDOR FOR COVER ALL COLORADANS POPULATION, EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

5.1. Due to uncertainty associated with coverage for the Cover All Coloradans (CAC) population, all applicable CAC cohorts for this time period shall be subject to a risk corridor calculation. The risk corridor will be calculated prior to the Medical Loss Ratio, and any reconciliations under the risk corridor will be incorporated as an adjustment to revenue within the Medical Loss Ratio calculation. (BH only) The CAC population will be excluded from the calculation of the Behavioral Health Incentive Program.

5.2. Population Covered

5.2.1. The following population cohorts will be included in the CAC risk corridor:

Program	Cohort
Physical Health	Prenatal/Delivery
Physical Health	Postpartum
Physical Health	Disabled Children

Behavioral Health	Prenatal/Delivery
Behavioral Health	Postpartum
Behavioral Health	Non-Disabled Children
Behavioral Health	Disabled Children

5.3. Calculation Process

5.3.1. The Department will calculate a CAC target PMPM as the medical portion of the actuarial sound PMPM for the contract period on a cohort basis.

5.3.2. CAC Adjusted Actual PMPM

5.3.2.1. The Department, or its designee, will calculate an adjusted actual PMPM for the contract period to be used in the risk corridor for the CAC population on a cohort level basis.

5.3.2.2. The numerator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, using the submitted encounter data with three months runout and submitted financial information, inclusive of Incurred but Not Reported (IBNR) information, on a cohort level. The denominator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, as the incurred member months for the contract period with three months runout as represented in the Department's system of record on a cohort level.

5.3.3. The Department, or its designee, will calculate the ratio between the CAC Adjusted Actual PMPM and the CAC Target PMPM to determine any cost sharing reconciliation based on the calculation table listed below.

5.3.4. The actuarially determined CAC Target PMPM is equivalent to one hundred percent (100%) in the risk corridor structure.

5.3.5. Risk corridor calculations will be made according to the following:

Corridor #	Risk Corridor Min	Risk Corridor Max	MCE Share	State Share
A	0.00%	94.99%	0%	100%
B	95.00%	98.99%	50%	50%
C	99.00%	100.99%	100%	0%
D	101.00%	104.99%	50%	50%
E	105.00%	+	0%	100%

5.4. Recoupments or Additional Reimbursement

5.4.1. From the above table, a ratio of greater than 100% indicates a payment due from the Department to Contractor. A ratio of less than 100% indicates a payment due from the Contractor to the Department.

5.4.2. After finalizing the risk corridor calculation, the Department will present the calculations to the Contractor and allow 7 Business Days for feedback.

5.4.3. The Department will issue a demand/notification letter for any amount due as recoupment from or payment to Contractor.

5.4.4. Contractor shall reimburse the Department, where applicable, within 60 days of the Department issuing the demand letter.

5.4.5. The Department shall reimburse Contractor, where applicable, for risk corridor calculations within 60 days of the Department issuing the notification letter.

6. BEHAVIORAL HEALTH RATES

CAC Category of Aid	Behavioral Health Rate SFY2025-26
Prenatal/Delivery	$188.07
Postpartum	$126.98
Children	$59.42
Disabled Children	$95.99

7. PHYSICAL HEALTH RATES

CAC Category of Aid	Physical Health Rate SFY2025-26
Prenatal/Delivery	$1,567.03
Postpartum	$394.78
Disabled Children	$1,353.24