

CONTRACT AMENDMENT NO. 1

Original Contract Number 2016ACCMMP01

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Rocky Mountain Health Maintenance Organization, Inc., 6251 Greenwood Plaza Boulevard, Suite 300, Greenwood Village, CO, 80111, (hereinafter called "Contractor"), and the STATE OF COLORADO, acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called "Department" or "State.")

2. EFFECTIVE DATE AND ENFORCEABILITY

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

3. FACTUAL RECITALS

The Parties entered into the Contract for the Contractor to act as a Regional Collaborative Care Organization for the Department, for the Accountable Care Collaborative: Medicare-Medicaid Program (ACC: MMP), in the Contractor's Region, as defined in Exhibit A, Statement of Work. The purpose of this Amendment is to update the statement of work.

4. CONSIDERATION

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

5. LIMITS OF EFFECT

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments thereto, if any, remain in full force and effect except as specifically modified herein.

6. MODIFICATIONS

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

- A. Exhibit A, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit A-1, Statement of Work, attached hereto and incorporated by reference into the Agreement. All references within the Agreement to Exhibit A, shall be deemed to reference to Exhibit A-1.

7. START DATE

This Amendment shall take effect on the later of its Effective Date or January 1, 2016.

8. ORDER OF PRECEDENCE

Except for the Special Provisions and the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The most recent version of the Special Provisions incorporated into the Contract or any amendment shall always control other provisions in the Contract or any amendments.

9. AVAILABLE FUNDS

Financial obligations of the state payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, or otherwise made available to the Department by the federal government, state government and/or grantor.

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THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

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


CONTRACTOR:

Rocky Mountain Health Maintenance
Organization, Inc.

STATE OF COLORADO:

John W. Hickenlooper, Governor

By: 
Signature of Authorized Officer

By: 
Susan E. Birch, MBA, BSN, RN
Executive Director
Department of Health Care Policy and
Financing

Date: 12/17/15

Date: 12/15/15

Michael E. Huotari
Printed Name of Authorized Officer

LEGAL REVIEW:
Cynthia H. Coffman, Attorney General

Vice President, Legal and Government Affairs
Printed Title of Authorized Officer

By: N/A

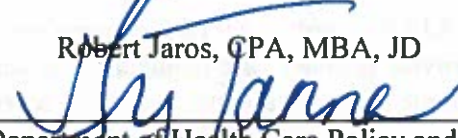
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ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

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

STATE CONTROLLER:

Robert Jaros, CPA, MBA, JD

By: 
Department of Health Care Policy and Financing

Date: 12/22/15

EXHIBIT A, STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ACRONYMS, ABBREVIATIONS AND DEFINITIONS

- 1.1.1. Acronyms and abbreviations are defined at their first occurrence in this Statement of Work. The following list of acronyms, abbreviations and definitions is provided to assist the reader in understanding acronyms, abbreviations and terminology used throughout this document.
- 1.1.1.1. ACC – Accountable Care Collaborative.
- 1.1.1.2. ACC Base Contract – Contract number 3211-0168 between the Department and Rocky Mountain Health Maintenance Organization, Inc.
- 1.1.1.3. ACC: MMP – Accountable Care Collaborative: Medicare-Medicaid Program – the Department’s demonstration to integrate care for full benefit Medicare-Medicaid enrollees.
- 1.1.1.4. ACC Program – The Department program designed to affordably optimize Client health, functioning and self-sufficiency with the primary goals to improve Medicaid Client health outcomes and control costs.
- 1.1.1.5. BHO – Behavioral Health Organization.
- 1.1.1.6. CCB – Community Centered Board.
- 1.1.1.7. C.C.R. – Colorado Code of Regulations.
- 1.1.1.8. CFR – Code of Federal Regulations.
- 1.1.1.9. Chief Medical Officer – The position within the Contractor’s organization responsible for the implementation of all clinical and/or medical programs.
- 1.1.1.10. Client – An individual eligible for and enrolled in the Colorado Medicaid Program.
- 1.1.1.11. Cold Call Marketing – Any unsolicited personal contact by the Contractor with a Potential Enrollee for the purpose of marketing as defined in 42 CFR 438.104(a). See Marketing.
- 1.1.1.12. CME – Continuing Medical Education.
- 1.1.1.13. Contract Manager – The position within the Contractor’s organization that acts as the primary point of contact between the Contractor and the Department.
- 1.1.1.14. Contractor’s PCMP Network – All of the providers who have contracted with the Contractor to provide primary care medical home services within the Contractor’s Region or to provide primary care medical home services to Members enrolled with the Contractor.
- 1.1.1.15. Contractor’s Region – The region in which the Contractor operates, in the case of this Contract, Region #1.

- 1.1.1.16. Covered Services – Medicaid benefits according to the Department’ State Plan, as filed with the federal Centers for Medicare and Medicaid Services, which are provided through the Department’s Promulgated Rules, Benefit Coverage Standards, Billing Manuals and Provider Bulletins.
- 1.1.1.17. CRS – Colorado Revised Statutes.
- 1.1.1.18. DCC Tool – Disability-Competent Care Tool.
- 1.1.1.19. DOC – Colorado Department of Corrections.
- 1.1.1.20. Enrollee – Any individual Client who is enrolled in the ACC: MMP with the Contractor or another RCCO.
- 1.1.1.21. EPSDT – Early Periodic Screening, Diagnosis and Treatment.
- 1.1.1.22. Essential Community Provider – A provider defined under CRS §25.5-5-403.
- 1.1.1.23. Expansion Adults – Adults who are newly eligible for and enrolled in Medicaid due to expanded Medicaid eligibility limits allowed by the Affordable Care Act (ACA).
- 1.1.1.24. FBMME - Full Benefit Medicare-Medicaid Enrollee, dually eligible for both Medicare and Medicaid.
- 1.1.1.25. Federally Qualified Health Center – A provider defined under 10 C.C.R. 2505-10 §8.700.1.
- 1.1.1.26. FFS – Fee For Service.
- 1.1.1.27. Financial Manager – The position within the Contractor’s organization that is responsible for the implementation and oversight of all of the Contractor’s financial operations.
- 1.1.1.28. FQHC – Federally Qualified Health Center.
- 1.1.1.29. Frail Elderly – Individuals who meet the following criteria: 1) greater than or equal to 65 years of age with 2 or more chronic conditions, 2) greater than eighty (80) years of age, 3) Sixty-five to seventy-nine (65-79) years of age with two (2) or more cognitive impairments listed in the ULTC (100.2), 4) Sixty-five to seventy-nine (65-79) years of age with two (2) or more Activities of Daily Living (ADL) deficits in the ULTC (100.2).
- 1.1.1.30. Informal Network – The non-contractual or contractual relationships with Providers, other than PCMPs, designed to meet Member’s needs.
- 1.1.1.31. Key Personnel – The individuals fulfilling the positions of Contract Manager, Financial Manager or Chief Medical Officer.
- 1.1.1.32. LTSS – Long-term Services and Supports.
- 1.1.1.33. Marketing – Any communication, from the Contractor, to a Medicaid Client who is not enrolled with the Contractor, that can reasonably be interpreted as intended to influence the Client to enroll in the Contractor’s Medicaid product, or either to not enroll in, or to disenroll from, another Contractor’s Medicaid product.

- 1.1.1.34. **Marketing Materials** – Materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.
- 1.1.1.35. **Medical Home** – An approach to providing comprehensive primary-care that facilitates partnerships between individual patients, their providers, and, where appropriate, the patient’s family, that meets the requirements described in **Exhibit C, Medical Home Model Principles**.
- 1.1.1.36. **Member** – Any individual Client who is enrolled in the ACC: MMP with the Contractor or another RCCO.
- 1.1.1.37. **Member Dismissal** – Termination of a Member’s primary care relationship with a contracted Primary Care Medical Provider.
- 1.1.1.38. **MMIS** – the Colorado Medicaid Management Information System.
- 1.1.1.39. **PCCM** – Primary Care Case Manager.
- 1.1.1.40. **Primary Care Case Manager** – A physician, a physician group practice, a physician assistant, nurse practitioner, certified nurse-midwife or entity that employs or arranges with providers to furnish primary care case management services or as described 42 CFR 438.2.
- 1.1.1.41. **Primary Care Medical Provider** – A primary care provider who serves as a Medical Home for Members. A PCMP may be a FQHC, RHC, clinic or other group practice that provides the majority of a Member’s comprehensive primary, preventive and sick care. A PCMP may also be individual or pods of PCMPs that are physicians, advanced practice nurses or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.
- 1.1.1.42. **PCMP** – Primary Care Medical Provider.
- 1.1.1.43. **PIP** – Performance Improvement Plan.
- 1.1.1.44. **PMPM** – Per Member Per Month.
- 1.1.1.45. **Potential Enrollee** – A Medicaid Client who is eligible for enrollment into the ACC: MMP with the Contractor or another RCCO.
- 1.1.1.46. **RCCO** – Regional Care Collaborative Organization.
- 1.1.1.47. **Region** – A geographical area containing specific counties, within the State of Colorado, that is served by a RCCO.
- 1.1.1.48. **Region #1** – The geographical area encompassing Archuleta, Delta, Delores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel and Summit Counties.
- 1.1.1.49. **Regional Care Collaborative Organization** – One of seven (7) regional entities contracted with the Department to support the ACC Program by improving the health outcomes for Members and controlling the cost of care.
- 1.1.1.50. **RHC** – Rural Health Clinic.

- 1.1.1.51. Rural Health Clinic – A provider or practice as defined in 10 C.C.R. 2505-10 §8.740.
- 1.1.1.52. SCP – Service Coordination Plan. The SCP will serve as the care plan for ACC: MMP Members as required by this Contract.
- 1.1.1.53. SDAC – Statewide Data Analytics Contractor.
- 1.1.1.54. SEP – Single Entry Point Agency.
- 1.1.1.55. STD – Sexually Transmitted Disease
- 1.1.1.56. ULTC – Uniform Long-Term Care (ULTC) Instrument. The Functional Needs Assessment and professional medical information used to determine Functional Eligibility for Long-Term Care.

SECTION 2.0 REGION AND PERSONNEL

2.1. REGION

- 2.1.1. The Contractor shall be the RCCO for Region #1 and shall be a Primary Care Case Manager (PCCM), as defined in 42 CFR §438.2, for Members enrolled with the Contractor. Region #1 includes Archuleta, Delta, Delores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel and Summit Counties.

2.2. PERSONNEL

- 2.2.1. The Contractor shall possess the corporate resources and structure necessary to perform its responsibilities under the Contract and successfully implement and operate the Accountable Care Collaborative: Medicare-Medicaid Program (ACC: MMP) in the Contractor’s Region.
- 2.2.2. The Contractor shall provide the following positions, defined as Key Personnel, in relation to the Contract. These positions may be filled by the same Key Personnel identified in the ACC Base Contract, as approved by the Department.
 - 2.2.2.1. Contract Manager
 - 2.2.2.1.1. The Contract Manager shall be the Department’s primary point of contact for contract and performance issues and responsibilities.
 - 2.2.2.1.2. All communication between the Department and the Contractor shall be facilitated by the Contract Manager.
 - 2.2.2.1.3. The Contract Manager shall ensure that all contract obligations are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.
 - 2.2.2.2. Financial Manager
 - 2.2.2.2.1. The Financial Manager shall be responsible for the implementation and oversight of the budget, accounting systems and all other financial operations of the Contractor.

- 2.2.2.2.2. The Financial Manager shall ensure that all financial operations of the Contractor are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.
- 2.2.2.3. Chief Medical Officer
 - 2.2.2.3.1. The Chief Medical Officer shall be a physician licensed by the State of Colorado and certified by the Colorado Board of Medical Examiners.
 - 2.2.2.3.2. The Chief Medical Officer shall be responsible for the implementation of all clinical and/or medical programs implemented by the Contractor.
 - 2.2.2.3.3. The Chief Medical Officer shall ensure that all clinical and/or medical programs implemented by the Contractor are implemented and operated in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.
- 2.2.3. Each Key Personnel position shall be filled by separate and distinct individuals. No individual shall be allowed to fulfill multiple Key Personnel positions simultaneously for this Contract.
- 2.2.4. The Contract Manager shall perform their responsibilities out of an office that is either located within the Contractor's Region or located in the Denver metro area.
- 2.2.5. Other Staff Functions
 - 2.2.5.1. The Contractor shall provide staff necessary to ensure that the following functions are performed, in addition to those of the Key Personnel:
 - 2.2.5.1.1. Outcomes and Performance Improvement Management, including overseeing Member and administrative outcomes, coordinating quality improvement activities across the Contractor's Region, benchmarking performance against other Regional Care Collaborative Organizations (RCCOs), ensuring alignment with federal and state guidelines, and setting internal performance goals and objectives.
 - 2.2.5.1.2. Medical Management and Care Coordination Activities, including overseeing medical management and care coordination activities to assist providers and Members in rendering and accessing necessary and appropriate services and resources.
 - 2.2.5.1.3. Communications Management, including organizing, developing, modifying and disseminating information, by way of written material and forums, to providers and Members.
 - 2.2.5.1.4. Provider Relations and Network Management, including establishing agreements with Primary Care Medical Providers (PCMPs), establishing all other formal and informal relationships with providers, provider education, data-sharing, and addressing providers' questions and concerns.
- 2.2.6. The Contractor shall maintain an office in the Contractor's Region and shall make Key Personnel, and other personnel requested by the Department, available for meetings in locations within the State of Colorado, at the Department's request.

- 2.2.7. The Contractor shall provide the Department with an organizational chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure and the names of the individuals fulfilling each position, within thirty (30) days of the Contract's Effective Date. The organizational chart shall contain accurate and up-to-date telephone numbers and email addresses for each individual listed.
- 2.2.7.1. DELIVERABLE: Organizational Chart.
- 2.2.7.2. DUE: Thirty (30) days from the Contract's Effective Date.
- 2.2.8. Contractor shall provide the Department with the opportunity to approve new Key Personnel working on the Contract. Any new Key Personnel shall have, at a minimum, the same qualifications as the individual previously fulfilling that position. The Contractor shall deliver an updated Organizational Chart within five (5) days of any change in Key Personnel or request from the Department for an updated Organizational Chart. The Contractor shall deliver to the Department an interim plan for fulfilling any vacant position's responsibilities and the plan for filling the vacancy.
- 2.2.8.1. DELIVERABLE: Updated Organizational Chart.
- 2.2.8.2. DUE: Five (5) days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.
- 2.2.9. The Contractor shall appoint any new Key Personnel only after a candidate has been approved by the Department to fill a vacancy.
- 2.2.10. The Department may request the removal from work on the Contract of employees or agents of the Contractor whom the Department justifies as being incompetent, careless, insubordinate, unsuitable or otherwise unacceptable, or who's continued employment on the Contract the Department deems to be contrary to the public interest or not in the best interest of the Department. For any requested removal of Key Personnel, the Department shall provide written notice to Contractor identifying each element of dissatisfaction with each Key Personnel, and Contractor shall have ten (10) business days from receipt of such written notice to provide the Department with a written action plan to remedy each stated point of dissatisfaction. Contractor's written action plan may or may not include the removal of Key Personnel from work on the Contract.

SECTION 3.0 MEMBERSHIP, ENROLLMENT AND CLIENT CONTACT

3.1. MEMBERSHIP AND ENROLLMENT

3.1.1. Enrollment and PCMP Selection

- 3.1.1.1. The Department will enroll Clients with the Contractor based on the Department's enrollment and reenrollment procedures. Only Clients who are eligible for the ACC: MMP will be passively enrolled into the ACC: MMP. Members are notified of the Department's intent to enroll them into the program at least thirty (30) days before they are enrolled. The Department's enrollment broker sends the Member a letter notifying them of the Department's intent to enroll them into the Program. The notification letter also includes instructions for disenrolling from the Program.

- 3.1.1.2. The Contractor shall accept all Clients, that the Department enrolls, that are eligible for enrollment. The Contractor shall accept individuals eligible for enrollment in the ACC: MMP in the order in which they are enrolled without restriction. The Department may enroll any Client who meets the following requirements:
- 3.1.1.2.1. Is enrolled in Medicare Parts A and B and eligible for Part D.
 - 3.1.1.2.2. Receives full Medicaid benefits under FFS arrangements.
 - 3.1.1.2.3. Has no other private or public health insurance.
 - 3.1.1.2.4. Is a resident of the State of Colorado.
- 3.1.1.3. Each Member shall have the option to select a PCMP to provide comprehensive primary-care to the Member and a majority of all of the Member's medical care. If a Member has not selected a PCMP prior to the Member's enrollment, the Contractor shall attempt to contact the Member and assist the Member in selecting a PCMP. The Contractor shall make a minimum of three (3) attempts to contact the Member, using at least two (2) different methods, if needed. The Contractor shall, on at least a quarterly basis, identify and implement strategies to reach Members whose phone or address information is incorrect. Once the Contractor has contacted the Member, it shall provide the Member with contact information for available PCMPs who are enrolling new Members in the ACC: MMP and assist the Member in selecting a PCMP. The Contractor may act as a liaison between the Member and any PCMP the Member wishes to select. The Contractor shall document all attempts at contacting Members who have not selected a PCMP and the results of each attempt. The Contractor shall maintain a record of all attempts made to contact a Member.
- 3.1.1.3.1. The Department shall provide the Contractor with a Member eligibility report and a Member eligibility change report, on a monthly basis. The Member eligibility report shall contain the PCMP selected by each Member in the Contractor's Region and the applicable demographics for each Member. The Member change report shall show any additions, deletions or changes to the existing PCMP selection records.
 - 3.1.1.3.2. The Contractor shall provide the results of the attempts to contact Members who have not selected a PCMP during the calendar quarter in the Stakeholder Report. The report shall also contain a plan for the following calendar quarter regarding Member contact and how the Contractor will resolve any deficiencies identified during the prior quarter.
- 3.1.1.4. Members have the option to select a PCMP or receive care within a Region other than the one in which they reside. In the event that a Member within Contractor's Region selects a PCMP or selects to receive care within another RCCO's Region, the Contractor shall coordinate with the other RCCO to ensure that the Member's quality, quantity and timeliness of care are not affected by the Member's choice.
- 3.1.1.4.1. The Department and Contractor shall work together to implement a report that will alert the Contractor when a Member in the Contractor's Region selects a PCMP in another Region so that the Contractor may coordinate with that other Region's RCCO.

- 3.1.1.5. The Contractor shall coordinate with any other RCCO, in the event that a Member residing within the other RCCO's Region selects a PCMP or selects to receive care within the Contractor's Region, to ensure that the Member's quality, quantity and timeliness of care are not affected by the Member's choice.
- 3.1.1.6. The Contractor shall only accept Members who reside within their Region and who reside sufficiently near the office of a PCMP in the Contractor's network for the Member to reach that PCMP within a reasonable time and using available and affordable modes of transportation.
- 3.1.1.7. The Contractor shall not discriminate against individuals eligible to enroll in the ACC: MMP on the basis of race, color or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.
- 3.1.1.8. The Contractor shall not discriminate against individuals eligible to enroll in the ACC: MMP on the basis of Member health status or need for health care services.
- 3.1.1.9. The Department will provide the Contractor with the following reports, from the Colorado Medicaid Management Information System (MMIS), for the Contractor to verify Member eligibility and enrollment:
 - 3.1.1.9.1. Daily Disenrollment.
 - 3.1.1.9.2. Monthly Enrollment Change.
 - 3.1.1.9.3. Monthly Report of All Enrollees.
 - 3.1.1.9.4. Daily New Enrollees.
 - 3.1.1.9.5. Monthly Disenrollments.
 - 3.1.1.9.6. Monthly New Enrollees.
 - 3.1.1.9.7. X12 transaction reports, including:
 - 3.1.1.9.7.1. Client Capitations.
 - 3.1.1.9.7.2. Benefit Enrollment and Maintenance.
 - 3.1.1.9.7.3. Eligibility Response.
 - 3.1.1.9.7.4. Acknowledgment of a sent transaction.
 - 3.1.1.9.8. Managed Care Transaction Report.
 - 3.1.1.9.9. Monthly Roster Report.
- 3.1.2. Disenrollment
 - 3.1.2.1. The Contractor may only request disenrollment of a Member from the ACC: MMP for cause. The Department shall review the Contractor's requests for disenrollment and may grant or reject the Contractor's request at its discretion. A disenrollment for cause may only occur under the following circumstances:
 - 3.1.2.1.1. The Member moves out of the Contractor's Region.

- 3.1.2.1.2. The Contractor's plan does not, because of moral or religious reasons, cover the service the Member seeks.
- 3.1.2.1.3. The Member needs related services to be performed at the same time, not all related services are available within the network and the Member's PCMP or another provider determines that receiving the services separately would subject the Member to unnecessary risk.
- 3.1.2.1.4. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Member's health care needs.
- 3.1.2.1.5. Abuse or intentional misconduct consisting of any of the following:
 - 3.1.2.1.5.1. Behavior of the Member that is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired.
 - 3.1.2.1.5.2. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.
 - 3.1.2.1.5.3. Behavior of the Member that poses a physical threat to the provider, to other provider, Contractor or PCMP staff or to other Members.
 - 3.1.2.1.5.4. The Contractor shall provide one oral warning to any Member exhibiting abusive behavior or intentional misconduct, stating that continuation of the behavior or misconduct will result in a request for disenrollment. If the Member continues the behavior or misconduct after the oral warning, the Contractor shall send a written warning that the continuation of the behavior or misconduct will result in disenrollment from the Contractor's plan. The Contractor shall send a copy of the written warning and a written report of its investigation into the behavior to the Department no less than thirty (30) days prior to the disenrollment. If the Member's behavior or misconduct poses an imminent threat to the provider, to other provider, Contractor or PCMP staff or to other Members, the Contractor may request an expedited disenrollment after it has provided the Member exhibiting the behavior or misconduct an oral warning.
 - 3.1.2.1.5.4.1. DELIVERABLE: Written warning and written report of abusive behavior or intentional misconduct.
 - 3.1.2.1.5.4.2. DUE: No less than thirty (30) days prior to disenrollment unless the Department approves expedited disenrollment.
 - 3.1.2.1.6. The Member commits fraud or knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor as part of the Member's enrollment in the Contractor's plan.
 - 3.1.2.1.7. Any other reason determined to be acceptable by the Department.
- 3.1.2.2. Disenrollment for cause shall not include disenrollment because of:
 - 3.1.2.2.1. Adverse changes in the Member's health status.

- 3.1.2.2.2. Change in the Member's utilization of medical services.
- 3.1.2.2.3. The Member's diminished mental capacity.
- 3.1.2.2.4. Any behavior of the Member resulting from the Member's special needs, as determined by the Department, unless those behaviors seriously impair the Contractor's ability to furnish services to that Member or other Members.
- 3.1.2.3. The Department may select to disenroll any Member at the Department's sole discretion. If the Department selects to disenroll a Member, the Department may reenroll that same Member with the Contractor at any time or with any other RCCO if the Member now resides within that other RCCO's Region.
- 3.1.2.4. The Department shall disenroll any Member, from the ACC: MMP upon that Member's request.
- 3.1.2.5. The Department may reenroll with the Contractor any Member who was disenrolled solely because the Member lost eligibility for Medicaid benefits and the loss was for a period of sixty (60) days or less.
- 3.1.2.6. The Contractor shall not discriminate against individuals eligible to re-enroll in the ACC: MMP on the basis of Member health status or need for health care services.
- 3.1.2.7. In the event that the Department grants a request for disenrollment, either from the Contractor or from a Member, 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 or Contractor files the request. If the Department fails to either approve or deny the request in this timeframe, the request shall be considered approved.
- 3.1.2.8. The Contractor shall have written policies that comply with the requirements of Exhibit D, Member Rights and Protections.
- 3.1.2.9. The Contractor shall ensure and document that PCMPs are in compliance with federal regulations regarding Member Dismissal. The Contractor shall only submit Member Dismissal requests that meet federal guidelines for Member Dismissal to the Department.
 - 3.1.2.9.1. When requesting that a Member be dismissed from a PCMP the Contractor shall submit this compliance documentation to the Department. The request and documentation shall be submitted to the Department no later than the 10th day of each month.
 - 3.1.2.9.2. The Department will process dismissals on the 10th day of each month; or the first Business Day following the 10th day, if the 10th falls on a weekend or holiday. Any request for a Member Dismissal received after the 10th will be processed in the following month.

3.2. CLIENT CONTACT RESPONSIBILITIES

- 3.2.1. All materials that the Contractor creates for distribution to any Client or Member shall be culturally and linguistically appropriate to the recipient.

- 3.2.1.1. All materials shall be written in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438. The Contractor shall notify all Members and potential Members of the availability of alternate formats for the information, as required by 42 CFR 438.10, and how to access such information.
- 3.2.1.2. All materials shall be written in easy to understand language and shall comply with all applicable requirements of 42 CFR 438.10.
 - 3.2.1.2.1. The Contractor shall ensure that written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department.
 - 3.2.1.2.2. The Contractor shall ensure that written information shall be translated into non-English languages prevalent in the Service Area, and that information is provided in alternative formats to meet the special needs of Clients who are visually impaired or have limited reading proficiency.
 - 3.2.1.2.3. The Contractor shall inform Members that oral interpretation services are available for any language, that written information is available in prevalent languages and how the Member may access interpretation services.
- 3.2.1.3. The Contractor shall use the messaging framework, developed and approved by the Department. The Contractor shall submit all materials to the Department at least ten (10) Business Days prior to the Contractor printing or disseminating such materials to any Member or Client, unless the Department approves a shorter submission deadline. The Department may review any materials and reserves the right to require changes or redrafting of the document as the Department determines necessary to ensure that the language is easy to understand. The Contractor shall make any required changes to the materials. Once a change is made to the materials, the Contractor shall not use any prior versions of the materials in any distribution to any Client or Member, unless the Department gives express written consent. This submission requirement shall not apply to items that are directed toward and addressed to individual Members.
 - 3.2.1.3.1. DELIVERABLES: All ACC: MMP client materials
 - 3.2.1.3.2. DUE: Ten (10) Business Days prior to the Contractor printing or disseminating materials to any Member or Client, unless the Department approves a shorter submission deadline.
 - 3.2.1.3.3. DELIVERABLES: Updated client materials including changes required by the Department.
 - 3.2.1.3.4. DUE: Thirty (30) days from the request by the Department to make a change.
- 3.2.2. The Contractor shall maintain, staff, and publish the number for at least one (1) toll free telephone line that Members may call regarding customer service or care coordination issues.
 - 3.2.2.1. The Contractor shall provide both English- and Spanish-speaking representatives to assist English- and Spanish-speaking Members and Clients, both through telephone conversations and in-person.

- 3.2.2.2. The Contractor shall assist any Member who contacts the Contractor, including RCCO Members not in the Contractor's region who need assistance with contacting his/her PCMP and/or RCCO. The Department will provide data to the RCCO on all Members for this purpose. If the Member does not have a PCMP, the Contractor shall assist the client in identifying a PCMP and making that selection with the enrollment broker.
- 3.2.3. The Contractor shall create and maintain the following materials:
 - 3.2.3.1. A section of the Department's ACC: MMP Member Handbook, that describes the Contractor's roles, responsibilities and functions that support the ACC: MMP, how to access the Contractor's care coordination services and relevant telephone numbers and website addresses. The information in this section shall be specific to the Contractor's Region.
 - 3.2.3.1.1. DELIVERABLE: ACC: MMP Member Handbook – updated section specific to the Contractor's Region whenever significant changes occur.
 - 3.2.3.1.2. DUE: Thirty (30) days from when changes take effect.
 - 3.2.3.2. A Directory of PCMPs
 - 3.2.3.2.1. DELIVERABLE: PCMP Directory.
 - 3.2.3.2.2. DUE: Monthly by the first day of the month, unless extension is allowed by the Department.
- 3.2.4. Marketing
 - 3.2.4.1. The Contractor may engage in Marketing Activities, as defined in 42 CFR 438.104, at its discretion. The Contractor shall not distribute any marketing materials without the Department's prior approval.
 - 3.2.4.1.1. The Contractor shall submit all materials relating to Marketing Activities to the Department's designee, and allow the Department's Night State Medical Assistance and Services Advisory Council and the Department to review any materials the Contractor proposes to use in relation to its Marketing Activities before distributing any such materials. Based on this review, the Department may require changes to any materials before the Contractor may distribute those materials, or may disallow the use of any specific materials in its sole discretion.
 - 3.2.4.1.2. The Contractor shall specify methods of assuring the Department that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the Members or the Department.
 - 3.2.4.1.3. The Contractor shall distribute the materials to the entire service area.
 - 3.2.4.1.4. The Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
 - 3.2.4.1.5. The Contractor and any Subcontractors shall not, directly or indirectly, engage in door-to-door, telephone, or other cold call marketing activities.

- 3.2.4.1.6. Marketing materials shall not contain any assertion or statement, whether written or oral, that the potential Member must enroll with the Contractor to obtain benefits or not to lose benefits.
- 3.2.4.1.7. Marketing Materials shall not contain any assertion or statement, whether written or oral, that the Contractor is endorsed by the Centers for Medicare and Medicaid Services, the Federal or State government or similar entity.
- 3.2.4.2. The Contractor shall only engage in Marketing Activities in compliance with federal and state laws, regulations, policies and procedures.
- 3.2.5. Upon termination of a PCMP's agreement or participation with the Contractor, for any reason, the Contractor shall notify any Member, who has selected that PCMP, of that PCMP's termination, as required in 42 CFR 438.10(f)(5).
- 3.2.5.1. DELIVERABLE: Notice to Members of PCMP termination.
- 3.2.5.2. DUE: Fifteen (15) days from the notice of termination.

SECTION 4.0 NETWORK STRATEGY

4.1. PCMP NETWORK AND NETWORK DEVELOPMENT

- 4.1.1. The Contractor shall create, administer and maintain a network of PCMPs and other Medicaid providers, building on the current network of Medicaid providers, to serve the needs of its Members.
- 4.1.2. The Contractor shall document its relationship with and requirements for each PCMP in the Contractor's PCMP Network in a written contract with that PCMP.
- 4.1.3. The Contractor shall only enter into written contracts with PCMPs that meet the following criteria:
 - 4.1.3.1. The PCMP practice and the individual PCMP are enrolled as a Colorado Medicaid provider.
 - 4.1.3.2. The PCMP practice and the individual PCMP, as applicable, are currently licensed by the Colorado Board of Nursing or Board of Medical Examiners to practice medicine in the State of Colorado.
 - 4.1.3.3. The individual PCMP shall act as the primary care provider for a Member and is capable of providing a majority of that Member's comprehensive primary, preventative and urgent or sick care.
 - 4.1.3.4. The PCMP practice is certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children Program or the PCMP practice is a Federally Qualified Health Center, a Rural Health Clinic, clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.
 - 4.1.3.5. The PCMP meets all additional criteria in **Exhibit C**.
 - 4.1.3.6. The Contractor may not prohibit a PCMP from entering into a contract with another RCCO.

- 4.1.4. The Contractor shall ensure that its PCMP network is sufficient to meet the requirements for every Member's Access to Care, to serve all Member's primary care needs and allow for adequate Member freedom of choice amongst PCMPs and providers.
- 4.1.5. The Contractor's network shall include Essential Community Providers and private for-profit and not-for-profit providers.
- 4.1.6. The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving Members and individuals in special populations that include, but are not limited to:
 - 4.1.6.1. The physically or developmentally disabled.
 - 4.1.6.2. Children and foster children.
 - 4.1.6.3. Adults and the aged.
 - 4.1.6.4. Non-English speakers.
 - 4.1.6.5. Members with complex behavioral or physical health needs.
 - 4.1.6.6. Members with Human Immunodeficiency Virus (HIV).
 - 4.1.6.7. The Frail Elderly.
 - 4.1.6.8. Members who are released from the Colorado Department of Corrections (DOC) or county jail system.
- 4.1.7. The Contractor's network shall provide the Contractor's Members with a meaningful choice in selecting a PCMP.
 - 4.1.7.1. The Contractor shall contact each primary care provider that qualifies as a PCMP that has provided care to any Members within the last twelve (12) months and is not a contracted PCMP to enroll the provider in the Contractor's network.
 - 4.1.7.2. The Contractor shall make an initial contact, through any method allowed by federal statutes, regulations, policies, or procedures.
 - 4.1.7.3. If the Contractor is unsuccessful in its initial contact, then the Contractor shall make four (4) follow-up contacts to attempt to enroll the provider in the Contractor's network.
 - 4.1.7.4. If a Member's primary care provider refuses to enroll in the Contractor's network, the Contractor shall inform the Member and explain the benefits of being attributed to a PCMP. If the client chooses to select a contracted PCMP, the Contractor will support the Member in making a selection.
- 4.1.8. The Contractor shall reasonably ensure that all providers and PCMPs in its network are aware of the requirement for a clinical referral when a Member receives services from another provider.

4.2. ACCESS TO CARE STANDARDS

- 4.2.1. The Contractor's PCMP Network shall have a sufficient number of PCMPs so that each Member has a PCMP and each Member has their choice of at least two (2) PCMPs within their zip code or within thirty (30) minutes of driving time from their location, whichever area is larger. For rural and frontier areas, the Department may adjust this requirement based on the number and location of available providers.
- 4.2.1.1. In the event that there are less than two (2) medical providers qualified to be a PCMP within the area defined in the prior paragraph for a specific Member, then the requirements of the above paragraph shall not apply to that Member.
- 4.2.1.1.1. During the Initial Phase, the Contractor shall contact all Medicaid participating specialists in the Contractor's Region regarding their Medicaid participation and office location. The Contractor shall update all information regarding these providers based on the results of these contacts.
- 4.2.1.2. The Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the providers and PCMPs in the Contractor's Region.
- 4.2.2. The Contractor's PCMP Network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. The Contractor will determine the appropriate requirements for the number of extended hours and weekend availability based on the needs of the Contractor's Region, and submit these requirements to the Department for approval. The Contractor shall assess the needs of the Contractor's Region on a regular basis, no less often than quarterly, and submit a request to the Department to adjust its requirements accordingly.
- 4.2.2.1. At a minimum, the Contractor's PCMP Network shall provide for twenty-four (24) hour a day availability of information, referral and treatment of emergency medical conditions.
- 4.2.3. The Contractor shall have a system to track Member access at the PCMP provider level, including requests for same day care, requests for routine care and how long a Member must wait before an appointment is available. The Contractor shall provide this information in a mutually agreed reporting format and on a mutually agreed schedule.
- 4.2.4. The Contractor's PCMP Network shall be sufficient to ensure that appointments will be available to all Members:
 - 4.2.4.1. Within forty-eight (48) hours of a Member's request for urgent care.
 - 4.2.4.2. Within ten (10) calendar days of a Member's request for non-urgent, symptomatic care.
 - 4.2.4.3. Within forty-five (45) calendar days of a Member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedules.
- 4.2.5. The Contractor shall reasonably ensure that Members in the Contractor's Region have access to specialists and other Medicaid providers promptly and without compromising the Member's quality of care or health.

- 4.2.6. The Department shall reimburse any provider for a Member's emergency services as otherwise authorized by Medicaid regardless of whether the provider that furnished the services has a contract with the Contractor.
- 4.2.7. In addition to primary care and other care required by this Contract, the Contractor shall assist Members in accessing the following services:
 - 4.2.7.1. Dental care for children.
 - 4.2.7.2. Prenatal and infant care.
 - 4.2.7.3. Infant and toddler early intervention services.
 - 4.2.7.4. Foster care services.
 - 4.2.7.5. Medicaid eligible dental care for adults.

4.3. ONGOING NETWORK MANAGEMENT AND REGIONAL STRATEGY

- 4.3.1. The Contractor shall develop relationships with providers and other community resources in the Contractor's Region and shall document its relationships with its informal network. .
- 4.3.2. The Contractor shall create, document, and maintain a Communication Plan to communicate with all providers, behavioral health managed care organizations and PCMPs in its network and other community resources with which it has relationships, and to promote communication amongst the providers.
 - 4.3.2.1. The Communication Plan may include the following methods:
 - 4.3.2.1.1. Assigning providers to a specific provider relations consultant or point-of-contact within the Contractor's organization.
 - 4.3.2.1.2. Holding information sessions for interested providers at practice association meetings or conferences.
 - 4.3.2.1.3. Providing orientation sessions for providers that are new to the Contractor's network.
 - 4.3.2.1.4. Hosting forums for ongoing training regarding the ACC: MMP and services the Contractor offers.
 - 4.3.2.1.5. Posting provider tools, trainings, informational material and the Contractor's contact details on the internet in easily accessible formats.
 - 4.3.2.1.6. Developing standard communication intervals at which the Contractor will contact providers to maintain connection and lines of communication.
 - 4.3.2.1.7. Distributing written provider communications at least twice a year to promote continuous provider interest and involvement.
 - 4.3.2.2. The Contractor shall submit an Updated Communication Plan when there are any significant changes to the Communication Plan for the Department's review and approval prior to implementation.
 - 4.3.2.2.1. DELIVERABLE: Updated Communication Plan.

- 4.3.2.2.2. DUE: Thirty (30) days prior to the date of any significant change to the Communication Plan.

SECTION 5.0 PROVIDER SUPPORT

5.1. ADMINISTRATIVE SUPPORT

- 5.1.1. The Contractor shall make all of the providers in its network aware of Colorado Medicaid programs, policies and processes within one (1) month of executing a contract with a that provider.
 - 5.1.1.1. This information shall include, but is not limited to, information regarding all of the following:
 - 5.1.1.1.1. Benefit packages and coverage policies.
 - 5.1.1.1.2. Prior authorization referral requirements.
 - 5.1.1.1.3. Claims and billing procedures.
 - 5.1.1.1.4. Eligibility and enrollment processes.
 - 5.1.1.1.5. Other operational components of service delivery.
 - 5.1.1.2. This information shall be delivered to providers during direct contact at meetings, forums, training sessions or seminars, or through any method of mailing, as defined in 10 C.C.R. 2505-10 §8.050.
 - 5.1.1.3. The Contractor shall submit all formal policy and procedure documents for provider support to the Department for review. The Department may request changes to the formal policy and procedure documents or plans for direct contact, and the Contractor shall make the changes and deliver the updated documents or plans to the Department.
 - 5.1.1.3.1. DELIVERABLE: All information documents and direct provider contact plans.
 - 5.1.1.3.2. DUE: Ten (10) Business Days from the date the documents or plans are requested by the Department; and ten (10) Business Days from the request by the Department to make a change for updated documents.
- 5.1.2. The Contractor shall make informational and educational materials available to providers regarding the roles that the Department, the Contractor and other Department contractors and partners play in the Colorado Medicaid system. These other Department contractors and partners shall include, at a minimum all of the following:
 - 5.1.2.1. The Statewide Data Analytics Contractor (SDAC).
 - 5.1.2.2. The Department's enrollment broker.
 - 5.1.2.3. The State's Medicaid fiscal agent.
 - 5.1.2.4. The Department's utilization management contractor.
 - 5.1.2.5. The Department's managed care ombudsman.
 - 5.1.2.6. The county Departments of Human and Social Services for the counties in the Contractor's Region.

- 5.1.2.7. The Community-Centered Boards and Single Entry Point agencies.
- 5.1.3. The Contractor shall act as a liaison between the Department and its other contractors and partners and the providers. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:
 - 5.1.3.1. Issues relating to Medicaid provider enrollment.
 - 5.1.3.2. Prior authorization and referral issues.
 - 5.1.3.3. Member eligibility and coverage policies.
 - 5.1.3.4. PCMP designation problems.
 - 5.1.3.5. PCMP Per Member Per Month (PMPM) payments.
- 5.1.4. Using the Department provided data on all Members, the Contractor shall assist all PCMPs (including those they are not contracted with), upon request, by providing information on the Provider's Members and their Members' RCCO assignments.

5.2. PRACTICE SUPPORT

- 5.2.1. The Department will provide the Contractor materials relating to behavioral health and the BHOs. The Contractor shall distribute these materials to all of the PCMPs in the Contractor's PCMP Network. The Department will direct the Contractor on the method for distributing these materials.
- 5.2.2. The Contractor shall offer support to PCMPs and providers, which may include comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities. The Contractor shall provide tools to the PCMPs and providers that may include any of the following:
 - 5.2.2.1. Clinical Tools:
 - 5.2.2.1.1. Clinical care guidelines and best practices.
 - 5.2.2.1.2. Clinical screening tools, such as depression screening tools and substance use screening tools.
 - 5.2.2.1.3. Health and functioning questionnaires.
 - 5.2.2.1.4. Chronic care templates.
 - 5.2.2.1.5. Registries.
 - 5.2.2.2. Client Materials:
 - 5.2.2.2.1. Client reminders.
 - 5.2.2.2.2. Self-management tools.
 - 5.2.2.2.3. Educational materials about specific conditions.
 - 5.2.2.2.4. Client action plans.
 - 5.2.2.2.5. Behavioral health surveys and other self-screening tools.
 - 5.2.2.3. Operational Practice Support:

- 5.2.2.3.1. Guidance and education on the principles of the Medical Home.
- 5.2.2.3.2. Training on providing culturally competent care.
- 5.2.2.3.3. Training to enhance the health care skills and knowledge of supporting staff.
- 5.2.2.3.4. Guidelines for motivational interviewing.
- 5.2.2.3.5. Tools and resources for phone call and appointment tracking.
- 5.2.2.3.6. Tools and resources for tracking labs, referrals and similar items.
- 5.2.2.3.7. Referral and transitions of care checklists.
- 5.2.2.3.8. Visit agendas or templates.
- 5.2.2.3.9. Standing pharmacy order templates.
- 5.2.2.4. Data, Reports and Other Resources:
 - 5.2.2.4.1. Expanded provider network directory.
 - 5.2.2.4.2. Comprehensive directory of community resources.
 - 5.2.2.4.3. Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line.
 - 5.2.2.4.4. Link from main ACC: MMP website to the Contractor's website of centrally located tools and resources.
- 5.2.3. Provider Support Accessibility
 - 5.2.3.1. The Contractor shall have an internet-accessible website that contains, at a minimum, all of the following:
 - 5.2.3.1.1. General information about the ACC: MMP, the Contractor entity, the Contractor's role and purpose and the principles of a Medical Home.
 - 5.2.3.1.2. A network directory listing providers and PCMPs with whom the Contractor has a contract, their contact information and provider characteristics such as gender, languages spoken, whether they are currently accepting new Medicaid clients and links to the provider's website if available.
 - 5.2.3.1.3. A provider page or section that contains a description of the support the Contractor offers to providers, an online library of available tools, screenings, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.
 - 5.2.3.1.4. A listing of immediately available resources to guide providers and their Members to needed community-based services, such as child care, food assistance, services supporting elders, housing, utility assistance and other non-medical supports.
 - 5.2.3.2. The Contractor shall make health disparity and cultural competency training available to the provider network on at least an annual basis.

- 5.2.4. The Contractor shall use a health information exchange, such as Quality Health Network, to facilitate improved clinical information sharing, where such services are available, and only to the extent that data is accessible under the terms of any applicable HIPAA Business Associate agreements.
- 5.2.5. The Contractor shall implement and maintain a Quality Improvement Program.
 - 5.2.5.1. The Quality Improvement Program shall:
 - 5.2.5.1.1. Credential and re-credential PCMPs with whom the Contractor contracts.
 - 5.2.5.1.2. Monitor and improve member access to and continuity of care through interdepartmental committee activities.
 - 5.2.5.1.3. Monitor and improve practitioner adherence to standards for preventive and chronic illness care.
 - 5.2.5.1.4. Monitor and improve practitioner adherence to standards for medical record keeping.
 - 5.2.5.1.5. Facilitate the development, distribution, and implementation of clinical practice guidelines of importance to Members in the Contractor's Region.
 - 5.2.5.1.6. Use results of performance measurement to continually improve care delivered to Members.
 - 5.2.5.1.7. Provide ongoing information or support to providers to support improvement of targeted performance measures, such as continuing medical education (CME) programs based on results of performance measurements and other quality improvement data.
 - 5.2.5.1.8. Promote quality and safety of clinical care by reviewing identified adverse patient outcomes, identifying and evaluating trends and taking corrective action if deemed warranted.
 - 5.2.5.1.9. Review and respond to Member and provider concerns and identify and evaluate related trends.
 - 5.2.5.1.10. Take action to address Member and provider concerns.
 - 5.2.5.1.11. Identify, through multiple mechanisms, important areas of care, safety and service to be monitored and initiate and complete necessary activities.
 - 5.2.5.1.12. Coordinate and facilitate the collection and utilization of quality improvement data pertinent to services provided to the Members in the Contractor's Region by contracting entities.
 - 5.2.5.2. The Contractor shall provide individuals to act as Quality Improvement Advisors. The Quality Improvement Advisors shall follow the minimum Quality Improvement Advisor Protocols listed in **Exhibit E**.
- 5.2.6. The Contractor shall provide interpreter services for all interactions with Members or Clients when there is no bilingual or multilingual Member of the Contractor available who speaks a language understood by a Member.

- 5.2.6.1. The Contractor may provide interpreter services for any PCMP in the Contractor's Region or any other provider with whom the Contractor has an agreement that the provider needs to interact with Members. Additionally, the Contractor shall ensure all PCMPs have access to interpreter services for all interactions with Members who are deaf or hard of hearing.
- 5.2.7. The Contractor may work with the Department to conduct a disability-competent care assessment of its provider network that provide care to Members. The Contractor may use the Disability Competent Care Tool to perform this assessment. The assessment may include an inventory of PCMPs that provide disability-competent care, including the types of services provided. The Contractor may work with the Department to determine the best way to disseminate to clients and providers the information collected from the assessment
 - 5.2.7.1. The Contractor may conduct the disability-competent care assessment of its provider network as prescribed by the Department, after consultation with the Contractor.
 - 5.2.7.2. The Contractor may work with the Department and partner with regional disability organizations to provide disability-competent care technical assistance to PCMPs.
- 5.2.8. The Contractor shall work with PCMPs to ensure that physical access and flexible scheduling is available for all Members that request it.

5.3. DATA ANALYSIS AND REPORTS

- 5.3.1. The Contractor shall provide reasonable network and care coordination data to the Department or to the SDAC at the Department's direction.
- 5.3.2. The Contractor shall access any reports, queries and searches it requires from the SDAC. The Contractor shall design any queries or searches it requires and interpret the results of the queries and searches it conducts.
 - 5.3.2.1. The Contractor shall share with the PCMPs, the SDAC and the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.
- 5.3.3. The Contractor shall educate and inform the PCMPs and providers about the data reports and systems available to the providers and the practical uses of the available reports.
- 5.3.4. The Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern and apply the information to make changes and improve the health outcomes of its members.
 - 5.3.4.1. The Department may request that the Contractor report the results of any analysis it performs. At the Department's request, the Contractor shall report the results of the analyses it performed to the Department and what steps it intends to take based on those analyses, within ten (10) Business Days of the Department's request. The Department may request additional information, that the Contractor perform further analyses or that the Contractor modify any steps it intends to take at the Department's sole discretion.

SECTION 6.0 MEDICAL MANAGEMENT AND CARE COORDINATION

6.1. REFERRAL PROCESS ASSISTANCE

- 6.1.1. The Contractor shall ensure that all PCMPs with which it contracts are aware of and comply with the Department's referral requirements. These requirements include referring the PCMP's Members to specialty care, as appropriate, and ensuring that clinical referrals are completed between PCMPs and specialists/referred providers to facilitate optimal health care, care coordination, and information sharing.
 - 6.1.1.1. The Contractor shall maintain a written protocol for clinical referrals to facilitate care coordination and sharing of relevant Member information and deliver those protocols to the Department for review and approval.
 - 6.1.1.2. The Department will review the Contractor's Clinical Referral Protocol and may direct changes. In the event that the Department directs changes, the Contractor shall make all changes to the Clinical Referral Protocol as directed by the Department.
 - 6.1.1.2.1. DELIVERABLE: Updated Clinical Referral Protocol including all changes directed by the Department.
 - 6.1.1.2.2. DUE: Within three (3) Business Days from the Department's request for a change, unless more time is granted by the Department.
 - 6.1.1.3. The Contractor shall implement the Clinical Referral Protocol upon Department approval.
 - 6.1.1.4. In the event that the Contractor desires to make a material change to its Clinical Referral Protocol, the Contractor shall deliver any updates to its Clinical Referral Protocol to the Department for review and approval.
 - 6.1.1.5. The Contractor shall not implement any material change to the Clinical Referral Protocol or updated Clinical Referral Protocol prior to the Department's approval of that protocol.
 - 6.1.1.6. The Contractors will work with providers and the Department to minimize administration burden on providers resulting from the Contractor's protocols.
- 6.1.2. The Contractor shall allow the PCMPs with which it contracts to refer Members to any specialists enrolled in Medicaid or any other Medicaid provider, including those not associated with the Contractor or another RCCO. The PCMP will not be required to provide an administrative referral for any fee for service benefit.
- 6.1.3. After the clinical referral protocol described in section 6.1.1.3 is implemented, the Contractor shall ensure that the goal of improved communication and care coordination is met and that clinical referrals are occurring.
 - 6.1.3.1. The Department may request and review data and supporting documentation from the Contractor to ensure compliance with this requirement. All such monitoring will be performed in a manner that will not unduly interfere with contract work.

6.2. MEDICAL MANAGEMENT SUPPORT

- 6.2.1. The Contractor shall use, and recommend to PCMPs, traditional and non-traditional medical management practices and tools to ensure optimal health outcomes and manage costs for the Department and the Contractor's Members. These practices and tools may include, but are not limited to, any of the following:
 - 6.2.1.1. Traditional methods:
 - 6.2.1.1.1. Coordination with the Department's utilization management contractor to detect inappropriate utilization of services.
 - 6.2.1.1.2. Integrating disease management into the care of Members with multiple chronic conditions.
 - 6.2.1.1.3. Catastrophic case management.
 - 6.2.1.1.4. Coordination of medical services for Members with serious, life-changing, and possibly life-threatening, illnesses and injuries.
 - 6.2.1.2. Innovative and proven or promising practices:
 - 6.2.1.2.1. Technologically enhanced communication, such as cell phone messages, email communication and text messaging.
 - 6.2.1.2.2. Providing PCMPs with tools and resources to support informed medical decision-making with Members.
 - 6.2.1.2.3. Alternate formats for delivering care.
 - 6.2.1.2.4. Methods for diversion to the most appropriate care setting.
- 6.2.2. The Department may review the Contractor's medical management practices and tools. In the event that the Department determines any practice or tool to be ineffective, inappropriate or otherwise unacceptable, the Contractor shall cease using or recommending that practice or tool immediately upon notification by the Department of its unacceptability.

6.3. PROMOTION OF MEMBER EMPOWERMENT, HEALTHY LIFESTYLE CHOICES AND INFORMED DECISION MAKING

- 6.3.1. The Contractor shall promote Member education and informed decision-making regarding healthy lifestyle choices, medical treatment and all aspects of the Member's own health care. This education shall include an overview of the ACC Program and how to navigate services within the Colorado Medicaid program. The Contractor's strategies may include, but are not limited to:
 - 6.3.1.1. A comprehensive approach to promoting healthy behavior that takes into consideration factors that affect healthy behavior, such as community and cultural practices and standards, daily work and life opportunities and limitations and Member awareness of how behavior affects health. This approach may include clinical, personal and community-based strategies, as appropriate.
 - 6.3.1.2. Motivational interviewing to create Member-centered, directive methods for increasing the member's intrinsic motivation to change behavior.
 - 6.3.1.3. Use of member decision aids.

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

6.3.2. The Department may review the Contractor's strategies for promoting Member education and informed decision-making. In the event that the Department determines any strategy to be ineffective, inappropriate or otherwise unacceptable, the Contractor shall cease using that strategy immediately upon notification by the Department of its unacceptability.

6.4. CARE COORDINATION

6.4.1. The Contractor shall provide care coordination for its Members, necessary for the Members to achieve their desired health outcomes in an efficient and responsible manner. The Contractor may allow the PCMPs, other Subcontractors, or other sources to perform some or all of the care coordination activities, but the Contractor shall be responsible for the ultimate delivery of care coordination services.

6.4.1.1. In the event that the Contractor allows a PCMP or other Subcontractor to perform any care coordination activities, the agreement with that PCMP or other Subcontractor shall comply with all requirements of the Contract.

6.4.1.1.1. The Contractor shall take steps to evaluate each PCMP or other Subcontractor's ability to perform the services that have been delegated to them by the Contractor.

6.4.1.1.2. The Contractor shall not pay 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 that:

6.4.1.1.2.1. Is furnished by an individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX of the Social Security Act (Act) or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), [203] of the Act.

6.4.1.1.2.2. Is furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX of the Act, or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

6.4.1.1.2.3. Is furnished by an individual or entity to whom the state 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 state determines there is good cause not to suspend such payments.

6.4.1.1.2.4. Includes any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

6.4.1.1.2.5. Includes any amount expended for roads, bridges, stadiums, or any items or services that are not covered under the Medicaid State Plan.

- 6.4.1.1.2.6. Includes home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.
- 6.4.1.1.3. The Contractor shall submit to the Department, care coordination agreements and/or descriptions, providing information on the roles and expectations of the non-PCMPs or other Subcontractors working with the Contractor on any care coordination activities, including SCP Completion.
 - 6.4.1.1.3.1. DELIVERABLE: Care Coordination Agreements and/or Description.
 - 6.4.1.1.3.2. DUE: Thirty (30) days from the Department's request.
- 6.4.1.2. The Contractor shall offer supports for the Contractor's care coordination staff and the care coordination staff of any PCMPs or Subcontractors to whom the Contractor has delegated care coordination responsibilities. These supports shall include, at a minimum:
 - 6.4.1.2.1. Identification and education of care management best practices.
 - 6.4.1.2.2. Ongoing training.
 - 6.4.1.2.3. Access to technical assistance through the Contractor's multi-disciplinary care management leadership team.
- 6.4.2. Regardless of its relationships or contracts with PCMPs or Subcontractors, the Contractor shall:
 - 6.4.2.1. Assess current care coordination services provided of its Members to determine if the providers involved in each Member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided.
 - 6.4.2.2. Provide all care coordination services that are not provided by another source.
 - 6.4.2.3. Work with providers who are responsible for the Member's care to develop a plan for regular communication with the person(s) who are responsible for the Member's care coordination.
 - 6.4.2.4. Reasonably ensure that all care coordination services, including those provided by other individuals or entities, meet the needs of the Member.
- 6.4.3. The Contractor shall develop a formal system of care coordination for its Members. This formal system shall have the following characteristics:
 - 6.4.3.1. Comprehensive Care Coordination characteristics include:
 - 6.4.3.1.1. Assessing the Member's health and health behavior risks and medical and non-medical needs, including determining if a care plan exists and creating a care plan if one does not exist and is needed.
 - 6.4.3.1.1.1. The care plan shall include a behavioral health component for those clients in need of behavioral health services.

- 6.4.3.1.2. The ability to link Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports. This ability to link may range from being able to provide Members with the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers and the Member.
- 6.4.3.1.3. Providing assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. This assistance shall promote continuity of care and prevent unnecessary re-hospitalizations and document and communicate necessary information about the Member to the providers, institutions and individuals involved in the transition.
 - 6.4.3.1.3.1. The Contractor shall provide, or work with community based organizations to arrange for, an individual to act as a Transition of Care Navigator for each Member during any transitions in this section. This individual shall communicate with every member to which they are assigned, once while they are in the hospital and again within forty-eight (48) hours of that Member's discharge, to help the Member receive the assistance that Member needs during their transition.
 - 6.4.3.1.4. Providing solutions to problems encountered by providers or Members in the provision or receipt of care.
 - 6.4.3.1.4.1. The Contractor shall use its existing grievance process to document all problems presented by Members in the provision or receipt of care and the solutions given to the Member. The Contractor shall also document problems presented by providers in the provision of care and the solutions provided to the provider. The Department may review any of the documented solutions and, should the Department determine the solution to be insufficient or otherwise unacceptable, may direct the Contractor to find a different solution or follow a specific course of action.
 - 6.4.3.1.5. Informing the Members of the Department's ACC: Medicare-Medicaid ombudsman, Medicaid ombudsman, or other ombudsman as directed by the Department, to assist the Member in resolving health care issues and filing grievances.
 - 6.4.3.1.6. Following up with Members to assess whether the Member has received needed services and if the Member is on track to reach their desired health outcomes.
- 6.4.3.2. Client/Family Centered characteristics include:
 - 6.4.3.2.1. Ensuring that Members, and their families if applicable, are active participants in the Member's care, to the extent that they are able and willing.
 - 6.4.3.2.2. Providing care and care coordination activities that are linguistically appropriate to the Member and are consistent with the Member's cultural beliefs and values.

- 6.4.3.2.3. The Contractor shall provide training related to special populations and barriers to care they may encounter due to socio-economic, cultural or disability status to all of its new clinical staff members. The Contractor shall provide updated training to all staff members as needed to address changes in training, to address issues that arise in relation to special populations or as requested by the Department.
- 6.4.3.2.4. Providing care coordination that is responsive to the needs of special populations, including, but not limited to:
 - 6.4.3.2.4.1. The physically or developmentally disabled.
 - 6.4.3.2.4.2. Children and foster children.
 - 6.4.3.2.4.3. Adults and the aged.
 - 6.4.3.2.4.4. Non-English speakers.
 - 6.4.3.2.4.5. All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act.
 - 6.4.3.2.4.6. Members in need of assistance with medical transitions.
 - 6.4.3.2.4.7. Members with complex behavioral or physical health needs.
 - 6.4.3.2.4.8. Members with HIV: In order to serve this population, the Contractor shall coordinate with the STD/HIV section of the Colorado Department of Public Health and Environment, which administers the Ryan White-funded program.
- 6.4.3.2.5. Providing care coordination that aims to keep Members out of a medical facility or institutional setting and provide care in the Member's community or home to the greatest extent possible. The Contractor shall ensure that all care coordination activities comply with the Supreme Court decision in *Olmstead v. L. C.* (527 U.S. 581 (1999)).
- 6.4.3.3. Integrated Care Coordination characteristics include:
 - 6.4.3.3.1. Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care.
 - 6.4.3.3.2. Providing services that are not duplicative of other services and that are mutually reinforcing.
 - 6.4.3.3.3. Implementing strategies to integrate member care such as:
 - 6.4.3.3.3.1. Developing a knowledge base of care providers, case management agencies and available services, both within the Contractor's network and the Members' communities.
 - 6.4.3.3.3.2. Becoming familiar with the Department's initiatives and programs.
 - 6.4.3.3.3.3. Knowing the eligibility criteria and contact points for community-based service available to the Member's in the Contractor's Region, subject to the Department's direction.

- 6.4.3.3.4. Identifying and addressing barriers to health in the in the Contractor's region, such as member transportation issues or medication management challenges.
- 6.4.3.4. The Contractor shall offer any necessary care coordination for Members who receive coverage under the Alternative Benefits Plan (ABP).
- 6.4.3.5. For Members who have been released from the Colorado Department of Corrections or county jail system, the Contractor shall coordinate with the Department of Corrections, counties, and the Members' BHO to ensure continuity of medical, behavioral, and pharmaceutical services.
- 6.4.3.6. The Contractor shall:
 - 6.4.3.6.1. Work with PCMPs to integrate and coordinate primary care, acute care, prescription drugs, behavioral health care and LTSS across Medicare and Medicaid for Members.
 - 6.4.3.6.2. Refer Members that could benefit from SEP or CCB Services.
 - 6.4.3.6.3. Work with existing delivery system, authorizing entities and specialty care/case managers to coordinate care for Members. The Contractor shall not duplicate functions provided within these systems of care.
- 6.4.3.7. The Contractor shall meet in person with all Members who are determined by the Department and the Contractor to be high risk and complete a Service Coordination Plan (SCP), within ninety (90) days of the Member's effective enrollment in the ACC: MMP. The Contractor shall work with all other Members to complete a SCP within one-hundred twenty (120) days of the Member's effective enrollment in the ACC: MMP. If the Contractor uses their own paper or electronic version of a SCP, it shall include all of the elements prescribed by the Department. The Service Coordination Plan shall serve as the care plan for the member. When the Contractor can confirm that a Member has an existing care plan through a SEP, CCB, BHO, or other Medicaid provider, the Service Coordination Plan is meant to complement the existing care plan.
 - 6.4.3.7.1. The Contractor shall ensure that the SCP is reviewed and updated as necessary with the Member, the Member's PCMP, and the Member's other service providers as appropriate. This review shall occur no less frequently than every six (6) months and after a critical incident (as specified by the SCP Guidelines).
 - 6.4.3.7.2. The Contractor shall participate in the Department's ACC: MMP Workgroup to work to improve the Demonstration and share best practices for:
 - 6.4.3.7.2.1. Care coordination.
 - 6.4.3.7.2.2. SCP completion and updating.
 - 6.4.3.7.2.3. Resource allocation.
 - 6.4.3.7.2.4. Grants to help with areas for improvement.

- 6.4.3.7.3. The Contractor shall coordinate with direct service providers to arrange for timely post-institutional or facility discharge follow-up, including medication reconciliation and substance abuse treatment and mental health care within 48 hours of a known admission of a Member to an institution or discharge from an institution.
- 6.4.3.7.4. The Contractor shall employ various strategies to improve care transitions between PCMPs, hospitals, nursing facilities and residential/rehabilitation facilities to provide prompt coordination of a Member's admission or discharge. Strategies may include in-person visits during hospitalization or nursing home stays, post-hospitalization and post-institutional stay home visits and telephone calls.
- 6.4.3.7.5. The Contractor shall ensure that services are person-centered and can accommodate and encourage beneficiary direction, that appropriate covered services are provided to beneficiaries, and that services are delivered in the least restrictive community setting in accordance with the Member's SCP.
- 6.4.3.7.6. The Contractor shall comply with written protocols between the Contractor and community partners and service providers that outline how the Contractor will work together with these partners to coordinate care and better serve Members. The protocols shall address partnerships with:
 - 6.4.3.7.6.1. BHOs.
 - 6.4.3.7.6.2. CCBs.
 - 6.4.3.7.6.3. Home Health Organizations.
 - 6.4.3.7.6.4. Hospitals.
 - 6.4.3.7.6.5. Hospice Organizations.
 - 6.4.3.7.6.6. SEPS.
 - 6.4.3.7.6.7. Skilled Nursing Facilities.
- 6.4.3.7.7. The Contractor shall inform the Department of community partners or service providers that are not in compliance with the written protocols.
- 6.4.4. The Contractor shall provide the Department with an updated documentation of its formal system of care coordination whenever it makes any significant change to its system, when a series of minor changes have combined into a significant change from the prior system or upon the Department's request. The Contractor shall deliver this documentation to the Department within sixty (60) days of the change or upon any request by the Department for updated documentation.
 - 6.4.4.1. DELIVERABLE: Updated documentation of formal system of care coordination.
 - 6.4.4.2. DUE: Sixty (60) days from the change or from the Department's request.

- 6.4.5. The Contractor shall attempt to contact any Member who accesses a hospital's emergency room, or are otherwise hospitalized, within thirty (30) days of the notification of the Member's discharge or emergency room visit, to explain the importance of the Medical Home concept and to help schedule an appointment with the Member's PCMP.
- 6.4.5.1. DELIVERABLE: Member contact for hospitalized Members.
- 6.4.5.2. DUE: Thirty (30) days from the Member's discharge from the hospital.
- 6.4.6. The Department may review the Contractor's formal system of care coordination at any time. The Department may direct changes in the Contractor's system of care coordination in the event that it determines any aspect of the system to be insufficient, inappropriate or otherwise unacceptable, for any reason. The Contractor shall immediately implement any changes directed by the Department and update its documentation of its formal system of care coordination accordingly.
- 6.4.7. The Contractor shall ensure coordination between behavioral health and physical health providers.
- 6.4.8. The Contractor shall classify each member in the Contractor's Region, based on their care utilization, according to the Care Coordination Levels shown in **Exhibit F**. The Contractor shall assign an individual to be a Care Coordinator for each Member, based on that Member's Care Coordination Level, to assist in transitioning the Member to the lowest possible Care Coordination Level.
 - 6.4.8.1. The Care Coordinator shall follow up with the Member at least:
 - 6.4.8.1.1. Biweekly for any Member classified as Level 4.
 - 6.4.8.1.2. Monthly for any Member classified as Level 3a or 3b.
 - 6.4.8.2. The Contractor shall provide support, via telephone, as requested by any Member of any classification level.
 - 6.4.8.3. The Contractor shall provide the services to each Member, based on that Member's Care Coordination Level, as described in **Exhibit F**.
 - 6.4.8.4. The Contractor shall arrange for training on poverty-related issues, such as the Contractor's Bridges out of Poverty training, to all of its Care Coordinators within three months of that staff member's placement as a Care Coordinator. The Contractor shall provide updated training to all staff members as needed to address changes in the training, to address issues that arise in relation to poverty-related issues or as requested by the Department.
 - 6.4.8.5. The Contractor shall seek consent from all Members, in the Contractor's Region, who seek care in the mental health system so that it may share this information with that Member's Care Coordinator.

6.4.9. The Contractor shall provide the Department with a report outlining its care coordination activities. The Contractor shall submit the report using a template that has been mutually agreed upon by the Contractor and the Department. The report shall describe the Contractor's approach to care coordination and stratification of Members within their Region and shall contain, at a minimum, narrative and statistics that address the following:

6.4.9.1. Direct care coordination activities of the Contractor:

6.4.9.1.1. The number of unique Members for whom care coordination services were provided by the Contractor during the reporting period.

6.4.9.1.2. The number of FTE, including level of licensure, the Contractor has dedicated and applied to care coordination.

6.4.9.1.3. The number of new care coordination cases initiated by the Contractor within the reporting period.

6.4.9.1.4. The number of established and on-going care coordination cases that were on file with the Contractor during the reporting period.

6.4.9.2. Delegated care coordination activities:

6.4.9.2.1. The number of entities to whom the Contractor has delegated care coordination responsibilities, including the number of FTE and level of licensure the delegated care coordination entity has dedicated and applied to care coordination.

6.4.9.2.2. The number of unique Members for whom care coordination services were provided by a delegated entity during the reporting period.

6.4.9.2.3. The number of FTE, including level of licensure, the delegated entities have dedicated and applied to care coordination.

6.4.9.2.4. The number of new care coordination cases initiated by delegated entities within the reporting period.

6.4.9.2.5. The number of established and on-going care coordination cases that were on file with delegated entities during the reporting period.

6.4.9.3. DELIVERABLE: Care Coordination Report

6.4.9.4. DUE: Semi-annually on November 1, reporting for the period of April 1 through September 30; and May 1, reporting for the period of October 1 through March 30.

6.4.10. The Contractor shall be responsible for all care coordination services required under this section 6.4 of this contract regardless of whether or not the Member is attributed to a PCMP.

6.5. PCMP CO-PAYMENT VOUCHERS

6.5.1. The Contractor may propose a co-payment voucher plan (plan) to the Department to issue vouchers for primary care visits to Members attributed to the Contractor. The goal(s) of the plan may include, but are not limited to:

6.5.1.1. Reducing the inappropriate utilization of emergency rooms.

- 6.5.1.2. Reinforcing utilization of primary care and preventative care.
- 6.5.1.3. Encouraging Member connection to a medical home.
- 6.5.1.4. Supporting Members upon determination of financial need.
- 6.5.1.5. Other goal(s), as proposed in the plan, if approved by the Department.
- 6.5.2. The Contractor shall submit a plan proposal to the Department for approval. The plan shall contain the following elements:
 - 6.5.2.1. A description of the plan, including plan goals, timeline for implementation, process for evaluating effectiveness of the plan and all of the following:
 - 6.5.2.1.1. The approximate number of PCMP co-payment vouchers to be issued on a per-month or annual basis.
 - 6.5.2.1.2. The criteria by which Members will be selected to receive PCMP co-payment vouchers.
 - 6.5.2.1.3. The format of the PCMP co-payment voucher and the method by which the voucher will be distributed to Members.
 - 6.5.2.1.4. The process whereby PCMPs will be reimbursed or compensated for the full amount of cost sharing waived.
 - 6.5.2.1.5. The process whereby the Contractor will resolve complaints that arise from Members not receiving co-pay vouchers, or complaints from non-contracted PCMPs unable to accept vouchers.
 - 6.5.2.1.6. The process for tracking the number of vouchers used by Members and where the vouchers are redeemed.
 - 6.5.2.1.7. An attestation that PCMPs and the Contractor have agreed to the manner and frequency of reimbursement.
- 6.5.3. In the event of a plan's approval, the Contractor shall pay for a Member's portion of primary care cost-sharing whenever a voucher is redeemed at a contracted PCMP. The Department shall not be liable for the Member's portion of cost-sharing.
- 6.5.4. To preserve Member choice, primary care co-payment vouchers or coupons must be redeemable at any ACC-contracted PCMP and must contain language to that effect. Irrespective of other arrangements with non-contracted primary care providers, the language printed on, or transmitted with, the voucher shall indicate that the voucher may only be used at a contracted PCMP.
- 6.5.5. The Contractor shall not specify a particular PCMP at which the voucher must be used. Language printed on, or transmitted with, the voucher or coupon shall not specify a particular PCMP by name.

SECTION 7.0 ACCOUNTABILITY

7.1. PERFORMANCE METRICS

- 7.1.1. The Department will use ACC: MMP specific quality measures to measure the Contractor's performance in the ACC: MMP. The measures include Federally mandated model core measures, State-specific process measures, and State-specific Demonstration measures that are part of the Pay for Performance Program for Members. The Department will work with the Centers for Medicare & Medicaid Services to establish benchmark performance targets for each measure. The Contractor shall monitor their performance as well as the performance of their contracted PCMPs on each measure. The Contractor shall provide practice support and quality improvement activities for PCMPs whose performance is below the established targets.
- 7.1.2. The Department will also use ACC: MMP specific Key Performance Indicators, developed in collaboration with the RCCOs, as part of the Pay for Performance Program. The Key Performance Indicators include Potentially Preventable Admissions (PPA), Thirty (30) Day All-Cause Re-admissions, and Depression Screening.

7.2. PERFORMANCE IMPROVEMENT

- 7.2.1. The Contractor shall submit an annual Quality Report and Quality Improvement Plan to the Department for approval. In your plan, include specific interventions/measures to address the needs of the ACC: MMP population, including activities targeting disabled clients and older adults with frail health. The report shall include:
 - 7.2.1.1. A description of the techniques used by the Contractor to improve its performance, effectiveness, and quality outcomes. This report shall describe the qualitative and quantitative impact the techniques had on quality and the overall impact and effectiveness of the quality assessment and improvement program.
 - 7.2.1.2. A description of past quality assessments and performance improvement activities targeted at creating a substantial improvements in the quality and results for next year.
 - 7.2.1.3. Findings and opportunities for improvement identified in studies, performance outcomes measurements, Member satisfaction surveys, and other monitoring quality activities.
 - 7.2.1.4. A description of annual activities related to practice support plans. These practice support activities shall be directed at a majority of the PCMPs in the Contractor's Region and may range from disseminating practice support resources to its PCMP network, to conducting formal training classes for PCMPs. Any data used to drive practice support plans shall be included.
- 7.2.2. The Contractor shall deliver the Quality Report and Quality Improvement Plan updates to the Department on an annual basis by October 1st of that year.
 - 7.2.2.1. DELIVERABLE: Initial Quality Report and Quality Improvement Plan; Annual Quality Report and Quality Improvement Plan update.
 - 7.2.2.2. DUE: The Initial Quality Report and Quality Improvement Plan is due by October 1, 2015; the Quality Report and Quality Improvement Plan Update is due annually, by October 1st of the year.

7.3. FEEDBACK AND INNOVATION

- 7.3.1. With permission from the Department, the Contractor shall use their existing Performance Improvement Advisory structure to provide community-level leadership and stakeholder input into the Contractor's implementation of the ACC: MMP and the Contractor's own performance improvement program.

SECTION 8.0 PROGRAM REPORTING

8.1. ADMINISTRATIVE REPORTING

- 8.1.1. The Contractor shall perform reporting as outlined below. With Department permission, the Contractor may include information required by this Contract in reports and deliverables the Department requires per the terms of the ACC Base Contract.

8.1.2. Network Report

- 8.1.2.1. The Network Report shall contain:

8.1.2.1.1. A listing of the total number of providers by type of provider and by county, including, but not limited to, PCMPs, specialists and hospitals.

8.1.2.1.2. The number of providers who are accepting new Clients.

8.1.2.1.3. A description of how the Contractor's network of providers and other community resources meet the needs of the Member population in the Contractor's Region, specifically including a description of how Members in special populations, as described in section 4.1.6, are able to access care.

8.1.2.2. In addition to the requirements for all network reports, the report submitted at the beginning of the Department's fiscal year shall include a summary of the challenges and opportunities for improving the Contractor's network, the existing unmet needs within the Contractor's network and the Contractor's strategy for meeting those needs.

8.1.2.3. The Contractor shall submit the network report on a semi-annual basis.

8.1.2.3.1. DELIVERABLE: Network Report.

8.1.2.3.2. DUE: Semi-annually, by January 31st and July 31st of each year.

8.1.2.4. The Department may request interim Network Reports, containing the same information normally contained in a semi-annual Network Report, from the Contractor at any time other than a semi-annual reporting period.

8.1.2.4.1. DELIVERABLE: Interim Network Report.

8.1.2.4.2. DUE: within ten (10) Business Days after the Department's request for the interim Network Report.

8.1.3. Program Integrity Report

8.1.3.1. The Contractor shall report to the Department any suspicion or knowledge of fraud or abuse, including, but not limited to, false or fraudulent filings of claims and the acceptance of or failure to return any monies allowed or paid on claims known to be fraudulent.

- 8.1.3.2. The Contractor shall report any suspicion or knowledge of fraud or abuse to the Department immediately upon receipt of the information causing suspicion or knowledge of the fraud or abuse.
- 8.1.3.3. The Contractor shall prepare a written program integrity report detailing the specific background information of any reported fraud or abuse, the name of the provider and a description of how the Contractor became aware of the information that led to the report. The Contractor shall deliver this Program Integrity Report to the Department within ten (10) business days from when it reported the fraud or abuse to the Department.
 - 8.1.3.3.1. DELIVERABLE: Program Integrity Report.
 - 8.1.3.3.2. DUE: Ten (10) Business Days from the initial report of the fraud or abuse.
- 8.1.3.4. The Contractor shall report any possible instances of a Member's fraud, such as document falsification, to the department of human or social services in the county in which the Member resides, immediately upon gaining information leading to knowledge of the fraud or suspicion of fraud. The Contractor shall deliver a written report of the possible instances of the Member's fraud detailing the specific background information of the reported fraud, the name of the Member and a description of how the Contractor became aware of the information that led to the report. The Contractor shall deliver this Member fraud report to the county department to which it made its initial report within ten (10) business days from when it reported the fraud to the county department.
 - 8.1.3.4.1. DELIVERABLE: Member Fraud Report.
 - 8.1.3.4.2. DUE: Ten (10) Business Days from the initial report of the fraud or abuse.

8.2. PERFORMANCE REPORTS

- 8.2.1. Integrated care
 - 8.2.1.1. The Contractor shall submit a semi-annual report describing all of the following:
 - 8.2.1.1.1. Integrated care efforts and continuing challenges.
 - 8.2.1.1.2. Updates on strategies identified in the existing Behavioral Health Integration Report.
 - 8.2.1.1.3. DELIVERABLE: Integrated Care Report.
 - 8.2.1.1.4. DUE: Semi-annually, by January 31st and July 31st of each year.
- 8.2.2. Member Outreach and Stakeholder Feedback Report
 - 8.2.2.1. The Member Outreach and Stakeholder Feedback Report shall contain:
 - 8.2.2.1.1. A summary of the feedback received from Members and other stakeholders, through any advisory committee or through any other means.
 - 8.2.2.1.2. A description of trends and themes in the feedback received.
 - 8.2.2.1.3. A description of overarching issues to address or system-wide problems that must be solved and a proposal to address these issues or solve the problems.

- 8.2.2.1.4. A summary of the feedback and complaints from Members, providers and the community at large and any advice or views expressed by the Contractor's Performance Improvement Advisory Committee.
- 8.2.2.1.5. The results of the prior quarter's attempts to contact Members as described in section 3.1.1.3.2, including the success rate of connecting Members without a PCMP to a PCMP.
- 8.2.2.1.6. The Contractor's plan for contacting Members without a PCMP during the following quarter.
- 8.2.2.2. The Contractor shall provide the Member Outreach and Stakeholder Feedback Report, to the Department, on a quarterly basis, within thirty (30) days from the end of the quarter that the report covers.
- 8.2.2.3. The Stakeholder feedback report may contain information that is not reflected in the Contractor's regular grievance process and the information contained in such a report is not indicative of a weakness or limitation of the Contractor or the Contractor's systems.
 - 8.2.2.3.1. DELIVERABLE: Member Outreach and Stakeholder Feedback Report.
 - 8.2.2.3.2. DUE: Semi-annually, by April 30th and October 31st of each year.
- 8.2.3. Financial Reporting
 - 8.2.3.1. The Contractor shall submit a quarterly financial report to the Department using a template that has been mutually agreed upon by the Contractor and the Department. The report shall contain a detailed accounting of the total revenue received during the quarter and how payments were spent.
 - 8.2.3.2. DELIVERABLE: Quarterly Financial Report.
 - 8.2.3.3. DUE: No later than forty-five (45) days from the end of the state fiscal quarter that the report covers.
- 8.2.4. ACC: MMP Report
 - 8.2.4.1. The Contractor shall provide the Department with a report outlining its activities for Members. The report shall address care coordination, network adequacy and disability-competent care. The Department shall work with the Contractor to develop the template for the report which shall contain narrative and statistics that address the following:
 - 8.2.4.1.1. Direct care coordination activities of the Contractor, including:
 - 8.2.4.1.1.1. A list of Members, including names and Client IDs, for whom:
 - 8.2.4.1.1.1.1. A new Service Coordination Plan was completed by the Contractor within the prescribed timelines during the reporting period.
 - 8.2.4.1.1.1.2. A new Service Coordination Plan was outside of the prescribed timelines during the reporting period.
 - 8.2.4.1.1.1.3. A current Service Coordination Plan was updated within 6 months of last update/initial creation during the reporting period.

- 8.2.4.1.1.1.4. A current Service Coordination Plan was updated in a period of greater than 6 months since the last update/initial creation during the reporting period.
- 8.2.4.1.1.1.5. The number and percentage of Clients discharged from a hospital, nursing facility, or other institutional setting who were contacted for care coordination within 3-7 days following discharge.
- 8.2.4.1.1.1.6. The number and type of referrals the Contractor provided for Members to protocol providers (SEPs, CCBs, BHOs, hospitals, home health Organizations, and hospice organizations).
- 8.2.4.1.2. Delegated care coordination activities, including the following for each delegated entity:
 - 8.2.4.1.2.1. A list of Members, including names and Client IDs, for whom:
 - 8.2.4.1.2.1.1. A new Service Coordination Plan was completed by delegated entities and the name of the delegated entity.
 - 8.2.4.1.2.1.2. A new Service Coordination Plan was completed by the delegated entities within the prescribed timelines during the reporting period.
 - 8.2.4.1.2.1.3. A new Service Coordination Plan was completed by the delegated entities outside of the prescribed timelines during the reporting period.
 - 8.2.4.1.2.1.4. A current Service Coordination Plan was updated by the delegated entities within 6 months of last update/initial creation during the reporting period.
 - 8.2.4.1.2.1.5. A current Service Coordination Plan was updated by the delegated entities in a period of greater than 6 months since the last update/initial creation during the reporting period.
 - 8.2.4.1.2.1.6. The number and percentage of Clients discharged from a hospital, nursing facility, or other institutional setting who were contacted for care coordination by the delegated entities within 3-7 days following discharge.
 - 8.2.4.1.2.1.7. The number and type of referrals the delegated entities provided for Members to protocol providers (SEPs, CCBs, BHOs, hospitals, home health organizations, and hospice organizations).
- 8.2.4.1.3. Care coordination challenges, including:
 - 8.2.4.1.3.1. A list of Members, including names and Client IDs, for whom:
 - 8.2.4.1.3.2. The Contractor or its delegate was not able to obtain accurate information for during the reporting period.
 - 8.2.4.1.3.3. The Contractor or its delegate attempted to contact at least three (3) times, using at least two (2) different methods, but did not receive a response during the reporting period.
 - 8.2.4.1.3.4. The Member refused care coordination during the reporting period.

- 8.2.4.1.4. Network Adequacy:
 - 8.2.4.1.4.1. The number of PCMPs contracted during the reporting period who had served as a primary care provider and had not been contracted PCMPs.
- 8.2.4.1.5. ACC: MMP Protocols:
 - 8.2.4.1.5.1. The number and types of providers (SEPs, CCBs, BHOs, hospitals, home health Organizations, skilled nursing facilities, and hospice organizations) the Contractor has contacted to comply with protocol requirements during the reporting period.
- 8.2.4.1.6. Disability-competent care:
 - 8.2.4.1.6.1. The Contractor shall report on the number of Providers and provide a description of activities being completed in their Region related to training on disability, cultural competence and health assessments during the reporting period.
- 8.2.4.2. DELIVERABLE: ACC: MMP Report
- 8.2.4.3. DUE: Quarterly, by the 10th day of the month following the end of the calendar quarter the report covers, starting in July 2015.

8.3. REPORT VERIFICATION

- 8.3.1. The Department may, in its sole discretion, verify any information the Contractor reports to the Department for any reason. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:
 - 8.3.1.1. Fact-checking.
 - 8.3.1.2. Auditing reported data.
 - 8.3.1.3. Requesting additional information.
 - 8.3.1.4. Performing site visits.
- 8.3.2. In the event that the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated report, which corrects all errors and includes all omitted data or information, and submit the updated report to the Department within ten (10) Business Days from the Department's request for the updated report.
 - 8.3.2.1. DELIVERABLE: Updated reports.
 - 8.3.2.2. DUE: Ten (10) Business Days from the Department's request for an updated or corrected report.

8.4. REPORT FORMAT OR TEMPLATES

8.4.1. The Contractor shall provide all reports in a format or template directed by the Department. The Department will develop the templates with input from the Contractor. The Contractor shall ensure that all reports comply with the specific guidance provided by the Department related to that report. With Department permission, the Contractor may include information required by this Contract in reports and deliverables the Department requires per the terms of the ACC Base Contract.

SECTION 9.0 COMPENSATION

9.1. PAYMENT

9.1.1. The Department will pay the Contractor a monthly ACC: MMP Payment. The ACC: MMP Payments for July 1, 2015 through December 31, 2015 are based on an estimated proportion of enrollees in the Contractor’s Region, relative to total population. The ACC: MMP Payments for January 1, 2016 through June 30, 2016 will be a monthly per member per month (PMPM) payment for each Member that is enrolled with the Contractor as of the first day of the month.

Period	Monthly Payment / Rate
July 1, 2015 through December 31, 2015	\$98,550.02 per month
January 1, 2016 through June 30, 2016	\$20.00 PMPM

9.2. PAY FOR PERFORMANCE PROGRAM

9.2.1. The Department may institute a pay for performance program for Members. In the event that the Department decides to institute a pay for performance program, it will work with the Contractor to develop targets and will amend this Contract as necessary to institute the program.

9.3. PAYMENT CALCULATION DISPUTES

9.3.1. In the event that the Contractor believes that the calculation or determination of any payment generated as incorrect, the Contractor shall notify the Department of its dispute within thirty (30) days of the receipt of the payment. The Department shall 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.

9.4. ADDITIONAL FEES OR CHARGES PROHIBITED

9.4.1. The Contractor shall not charge any fees or premiums to Members for services or materials they receive from the Contractor, its subcontractors, or any other entity.

9.4.1.1. For fees or premiums charged by the Contractor to Members, the Contractor may be liable for penalties of up to twenty-five thousand dollars (\$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.

SECTION 10.0 TRANSITION AT TERMINATION

10.1. CONTRACTOR'S TRANSITION REQUIREMENTS

- 10.1.1. Upon termination of the Contract for any reason, the Contractor shall do all of the following for a period not to exceed sixty (60) days before termination of the Contract:
 - 10.1.1.1. Provide the Department with all information related to the Contractor's PCMP Network, its Members and the services provided to those Members, for transition to the Department or any other contractor of the Contractor's responsibilities.
 - 10.1.1.2. Provide for the uninterrupted continuation of all network management, care coordination and administrative services until the transition of every Member is complete and all requirements of the Contract are satisfied.
 - 10.1.1.3. Designate an appropriate individual as the transition coordinator to work with the Department and any staff from the replacement contractor to ensure the transition does not adversely impact any member's care.
 - 10.1.1.4. Provide to the Department all reports reasonably necessary for a transition.
 - 10.1.1.5. Notify any Subcontractors of the termination of the Contract, as directed by the Department.
 - 10.1.1.6. Notify all of the Members in the Contractor's Region that the Contractor will no longer be the RCCO for the region, in a form and manner approved by the Department.
 - 10.1.1.7. Notify each PCMP in the Contractor's PCMP Network of the termination and the end date of the Contract and explain to the provider how the provider may continue participating in the ACC Program.
 - 10.1.1.8. Cooperate with the Department and any other replacement contractor during the transition, including, but not limited to, using reasonable efforts to share and transfer Member information and following any instructions or performing any required actions, as reasonably directed by the Department.
 - 10.1.1.9. Provide the Department, in a format prescribed and approved by the Department:
 - 10.1.1.9.1. A list of all PCMPs in the Contractor's PCMP Network.
 - 10.1.1.9.2. A list of all Members in the Contractor's Region.

SECTION 11.0 GENERAL REQUIREMENTS

11.1. CONTRACTORS AND SUBCONTRACTORS

- 11.1.1. Department Contractors
 - 11.1.1.1. The Department may, in its sole discretion, use another contractor to perform any of the Department's responsibilities contained in the Contract. The Contractor shall work in coordination with any of these other contractors at the Department's direction. Any reference to the Department shall also include reference to its contractors as applicable.
- 11.1.2. Subcontractors

- 11.1.2.1. Other than the care coordination provided by any PCMP, the Contractor shall not subcontract more than forty percent (40%) of its responsibilities under the Contract, based on the total annual Contract value, to any other entity and it shall not subcontract more than twenty percent (20%) of its responsibilities under the Contract, based on the total annual Contract value, to any single entity.
- 11.1.2.2. The Contractor shall not enter into any agreement with a Subcontractor or have any Subcontractor begin work in relation to the Contract until it has received the express, written consent of the Department to subcontract with the specific Subcontractor. This consent requirement shall only apply to subcontracts that relate to ten percent (10%) or more of the responsibilities under the Contract, based on the total annual Contract value.
- 11.1.2.3. Any agreement the Contractor has with a Subcontractor shall be in writing and shall require compliance with all of the terms in this Contract.

11.2. NO MEDICAL TREATMENT DIRECTION

- 11.2.1. The Contractor may make recommendations and provide support to PCMPs and their Members to improve health outcomes, but shall not, under any circumstance, direct treatment or require the PCMP or Member to make any decision regarding that Member's health care.
- 11.2.2. The Contractor may not create or make any referrals, on behalf of any Member or provider, in its role as a RCCO. Only a provider may create or make any referrals, and the Contractor may facilitate the referral process and provide support for providers when the provider creates or makes a referral.

11.3. DUE DATE AND TIMELINES

- 11.3.1. All due dates, deadlines and timelines in this Statement of Work are measured in calendar days unless specifically stated otherwise. Additionally, all due dates, deadlines and timelines in this Contract, based on quarters, refer to state fiscal year calendar quarters, with the first quarter beginning on July 1st of each year. In the event that any due date or deadline falls on a weekend, a Department holiday or other day the Department is closed, the due date or deadline shall be automatically extended to the next business day the Department is open.
- 11.3.2. The Department may, in its sole discretion, extend the due date, deadline or timeline of any activity, deliverable or requirement under this Statement of Work. Any such extension shall only be valid if it is delivered to the Contractor in writing, in either a hard copy or electronic format.
- 11.3.3. All Contract deliverables shall be submitted electronically to acc@state.co.us, the Department's contract manager, and other Department staff, as directed by the Department.

11.4. CYBER SECURITY

- 11.4.1. The Contractor shall ensure that all of its information technology systems and websites are operated and maintained in compliance with all state and federal statutes, regulations and rules and all State of Colorado Cyber Security Policies, in accordance with a reasonable implementation plan.

11.5. DISPUTES BETWEEN RCCOS

11.5.1. The Contractor shall cooperate with any other RCCO to resolve any dispute, regarding the ACC: MMP's policies, between the Contractor and the RCCO relating to any ACC: MMP related issue, including, but not limited to, issues relating to providers within the ACC: MMP, Members, performance target measurements or ACC: MMP Payments. If the Contractor and another RCCO are unable to reach a resolution to the dispute, the Contractor shall submit a notice of the dispute to the Department. The Department may conduct any investigation or hearing it deems appropriate to the dispute, and shall make a final determination on the dispute. The Contractor shall abide by the Department's decision relating to any dispute described in this section.

11.6. DEBARRED ENTITIES

11.6.1. In addition to the Debarment and Suspension provisions in §21(C) of this Contract, the Contractor shall not knowingly have a relationship with any of the following entities:

11.6.1.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.

11.6.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in the prior paragraph.

11.6.2. For the purposes of this section, a relationship is described as:

11.6.2.1. A director, officer or partner of the Contractor.

11.6.2.2. A person or entity with more than five percent (5%) beneficial ownership of the Contractor.

11.6.2.3. A Person with an employment, consulting or other arrangement with the Contractor that is responsible for any of the Contractor's obligations under this Contract.

11.6.3. As stipulated in 42 CFR 438.610(c), if the Department finds that the Contractor is not in compliance with any provisions of this Section 11.6, the Department:

11.6.3.1. Must notify the Secretary of the U.S. Department of Health and Human Services (Secretary) of the noncompliance.

11.6.3.2. May continue an existing agreement with the Contractor, unless the Secretary directs otherwise.

11.6.3.3. May not renew or otherwise extend the duration of this Contract unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending this Contract.

11.7. FEDERAL INTERMEDIATE SANCTIONS

11.7.1. The Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if the Department makes the determination to impose sanctions under 42 CFR 438.700.

11.7.2. Before imposing any intermediate sanctions, the Department shall give the Contractor timely written notice that explains:

11.7.2.1. The basis and nature of the sanction.

11.8. TERMINATION UNDER FEDERAL REGULATIONS

11.8.1. The Department may terminate this Contract for cause and enroll any Member enrolled with the Contractor in other RCCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan if the Department determines that the Contractor has failed to:

11.8.1.1. Carry out the substantive terms of its contracts.

11.8.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

11.8.2. Before terminating the Contractor's Contract as described in this section, the Department shall:

11.8.2.1. Provide the Contractor a cure notice that includes, at a minimum, all of the following:

11.8.2.1.1. The Department's intent to terminate.

11.8.2.1.2. The reason for the termination.

11.8.2.1.3. The time and place for the pre-termination hearing

11.8.2.2. Conduct a pre-termination hearing.

11.8.2.3. Give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

11.8.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to the Contractor that contains the effective date of the termination.

11.8.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the Contractor notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

11.8.3. Once the Department has notified the Contractor of its intent to terminate under this section, the Department may:

11.8.3.1. Give the Members enrolled with the Contractor written notice of the State's intent to terminate the Contract.

11.8.3.2. Allow Members enrolled with the Contractor to disenroll immediately, without cause.

11.9. INFORMATION AVAILABILITY

11.9.1. The parties acknowledge and agree that the ability of the Contractor to perform and optimize many of the functions contemplated under this agreement, including quality improvement, population health management and care coordination functions, will depend, in part, upon the timely, complete and accurate production of claims, demographic, authorization and related data by the Department. The Department and Contractor agree to prioritize the implementation and maintenance of robust, effective data reporting mechanisms that support the Contractor's ability to perform these functions, in accordance with Contractor's responsibility to reduce aggregate Medicaid program costs, improve health outcomes and patient experience. The parties affirm their reciprocal accountability for the production of Medicaid program data and for the achievement of Accountable Care Collaborative goals.

11.10. RETROSPECTIVE ENROLLMENT AND DISENROLLMENT

11.10.1. The Department may retroactively enroll Members for a period of not more than ninety (90) days in its discretion.

11.10.2. In the event of retrospective disenrollment, the Department will attempt to recoup any payments made:

11.10.2.1. After the date of a Member's death.

11.10.2.2. When a Member is determined to be in another state or to have otherwise received services in another state.

11.11. FEDERAL DISCLOSURES OF INFORMATION ON OWNERSHIP AND CONTROL

11.11.1. The Contractor shall provide all disclosures required by 42 CFR 455.104, as amended or hereinafter amended. These disclosures are:

11.11.1.1. The name and address of any person, either an individual or a corporation, with a direct, indirect, or combined direct/indirect ownership or control interest in the Contractor. For a corporate entity, the address shall include the primary business address, the address of each business location if there is more than one location and any applicable P.O. Box address.

11.11.1.1.1. The date of birth and social security number for any individual with an ownership or control interest in the Contractor.

11.11.1.1.2. The tax identification number of any corporate entity with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five percent (5%) or greater interest.

11.11.1.2. Whether any person, either an individual or a corporation, with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

11.11.1.3. Whether any person, either an individual or a corporation, with an ownership or control interest in the any subcontractor in which the Contractor has a five percent (5%) or greater interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

- 11.11.1.4. The name of any person or corporation that owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets.
 - 11.11.1.5. The name of any person who is an officer or director of a Managed Care Entity, as defined by Section 1932 of the Social Security Act, organized as a corporation.
 - 11.11.1.6. The name of any person or corporation who is a partner in a Managed Care Entity organized as a partnership.
 - 11.11.1.7. The name of any other entity required to disclose under 42 CFR 455.104 in which any owner of the Contractor has an ownership or control interest.
 - 11.11.1.8. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.
 - 11.11.2. "Ownership interest" and "person with an ownership or control interest" shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended. "Subcontractor", for purposes of this subsection 11.11 only, shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended.
 - 11.11.3. The Contractor shall complete these disclosures when any of the following occur:
 - 11.11.3.1. Submission of a provider application
 - 11.11.3.2. Execution of the Contract
 - 11.11.3.3. Upon request of the Department during the revalidation of the provider enrollment
 - 11.11.3.4. Within thirty-five (35) days of any change in ownership of the Contractor.
- 11.12. SDAC ACCESS COMPLIANCE**
- 11.12.1. The Contractor shall comply with the Department's SDAC Web Portal access policy.

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