COLORADO

Department of Health Care Policy & Financing

REQUEST FOR INFORMATION

[ENTER CORE ID#]

Regional Accountable Entity for the Accountable Care Collaborative

DRAFT RFP Release

Released: November 4, 2016

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY.
THIS IS NOT A FORMAL BID SOLICITATION.

NO AWARD WILL RESULT FROM THIS RFI.

PURPOSE OF RELEASING THIS DRAFT RFP

The Colorado Department of Health Care Policy and Financing (Department) is responsible for administering Health First Colorado, Colorado's Medicaid program. On November 4, 2016, the Department released a draft of its Accountable Care Collaborative RFP Package for review and comment. Please remember that it is a draft RFP, which has not undergone a thorough review by Department procurement staff or by management. This draft may contain areas that have not been fully developed at this time.

The Department feels it is important to receive feedback from all stakeholders at this stage of drafting and will incorporate suggestions, as appropriate, in the final RFP.

The Department is requesting stakeholders to send comments to the Department. Stakeholders are encouraged to address text in the draft RFP that is confusing, requirements that are incomplete or unclear, and requirements that are too broad or restrictive, which will inadvertently cause a significant cost increase or cause a vendor to make a no-bid decision.

The Department encourages vendors and stakeholders to submit feedback regarding the Accountable Care Collaborative RFP as soon as possible. Stakeholders do not need to wait until January 13, 2017 to submit comments.

INSTRUCTIONS FOR SUBMITTING COMMENTS ON THE DRAFT RFP

To encourage thoughtful and detailed comments, the Department provides the following for Stakeholders to consider:

- How well does the draft RFP meet the overall goals of Accountable Care Collaborative Phase II?
- What operational concerns and potential consequences are there for implementing the requirements in the draft RFP as written?
- What draft requirements need additional clarification in the draft RFP as written?

The Department is also seeking information specifically from potential Vendors regarding the following questions.

1. If a Vendor is considering a no-bid decision, please specify what the Department could modify to encourage a Vendor to submit a proposal.

Wraparound Program

2. Do you feel the Wraparound Program can be incorporated into the overarching scope of work for this RFP? What are the benefits and/or risks of including this additional responsibility?
3. Is the per member per month funding range of $800–$1,000 in section 7.3.2 of the RFP appropriate and viable for the total administration costs of the program? If not, what is the appropriate funding level?

Pre-Admission Screening and Resident Review (PASRR)

4. Do you feel PASRR can be incorporated into the overarching scope of work for this RFP? What are the benefits and/or risks of including this additional responsibility?

5. What is the appropriate compensation for funding the administration of PASRR? Is the compensation in section 7.5.4 of the RFP adequate for funding PAS Level II assessments described in the scope of work? If not, what is the appropriate compensation?

Brokering of Case Management

6. Do you feel the Brokering of Case Management can be incorporated into the overarching scope of work for this RFP? What are the benefits and risks of including this additional responsibility?
7. What is the appropriate compensation for funding the Case Management Brokering Services?

Vendors and Stakeholders may provide feedback through written comments only.

To submit written comments, Stakeholders and Vendors must:

1. Submit all comments using the online form located at Colorado.gov/HCPF/ACCPhase2.
2. Make no direct contact with Department staff.
3. Send all comments and questions on the draft RFP Package no later than January 13, 2017 at 5:00 pm MT.

For additional information on how to provide feedback, go to Colorado.gov/HCPF/ACCPhase2.

Table of Contents

SECTION 1.0 INTRODUCTION

1.1 GENERAL INFORMATION

1.1.1 The Colorado Department of Health Care Policy and Financing (Department) is soliciting competitive, responsive proposals from experienced and financially sound organizations to perform as a Regional Accountable Entity for the Department.

1.2 ANTICIPATED CONTRACT TERM

1.2.1 The Contractor's start-up period is anticipated to begin on February 1, 2018 and end on June 30, 2018.

1.2.2 The initial operational period of the Contract is anticipated to begin at the end of the start-up period and will last for one (1) year.

1.2.3 The total duration of the Contract, from the Operational Start Date until termination, and including the Department's exercise of any options, is not anticipated to exceed seven (7) years. The Department may extend the Contract beyond the anticipated term in this subsection, in accordance with the Colorado Procurement Code and its implementing rules, if the Department determines the extension is necessary to align the Contract with other Department contracts to address state or federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.

SECTION 2.0 TERMINOLOGY

2.1 ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY

2.1.1 Acronyms and abbreviations are defined at their first occurrence in this Request for Proposals (RFP). The following list is provided to assist the reader in understanding acronyms, abbreviations and terminology used throughout this document.

2.1.2 1915(b)(3) Services – Alternative, non-State Plan Services described in 42 C.F.R. § 440 and provided under the Departments 1915(b)(3) waiver such as: intensive case management, Assertive Community Treatment (ACT), respite care, vocational services, clubhouses and drop-in center services, recovery services, educational and skills training courses, prevention/early intervention and residential services.

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

2.1.4 Appeal – A review by a managed care organization of an adverse benefit determination.

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

2.1.6 Business Day – Any day in which the Department is open and conducting business, but shall not include weekend days or any day on which the Department observes one of the following holidays:

2.1.6.1 New Year's Day.

2.1.6.2 Martin Luther King, Jr. Day.

2.1.6.3 Washington-Lincoln Day (also referred to as President's Day).

2.1.6.4 Memorial Day.

2.1.6.5 Independence Day.

2.1.6.6 Labor Day.

2.1.6.7 Thanksgiving Day.

2.1.6.8 Christmas Day.

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

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

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

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

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

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

2.1.13 Case Management Agency (CMA) – An agency that employs case managers who assist in planning, coordination, monitoring and evaluation of services and supports for Clients enrolled in Long-Term Services and Supports (LTSS) programs.

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

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

2.1.16 Closeout Period – The period beginning on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice by the Department of non-renewal, and ending on the day that the Department has accepted the final deliverable for the Closeout Period and has determined that the final transition is complete.

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

2.1.18 Center for Medicare and Medicaid Services (CMS)

2.1.19 Code of Federal Regulations (CFR)

2.1.20 Colorado Opportunity Project – A multi-state agency program to deliver evidence-based initiatives and Community-based promising practices that remove roadblocks for all Coloradans, so that everyone will have the opportunity to reach and maintain their full potential.

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

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

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

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

2.1.25 Contract – The agreement that is entered into as a result of this solicitation.

2.1.26 Contractor – The individual or entity selected as a result of this solicitation to complete the Work contained in the Contract.

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

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

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

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

2.1.31 Delivery System Reform Incentive Payment (DSRIP) – a waiver program under section 1115 of the Social Security Act that provides incentive payments to providers who meet certain milestones or metrics.

2.1.32 Early Periodic Screening, Diagnostic and Treatment (EPSDT) — The EPSDT benefit includes services that are federally mandated by 42 C.F.R. § 441.55 and provides preventative and comprehensive health care to all Medicaid-eligible children through periodic screenings, diagnostic and treatment services as described in 42 C.F.R. § 440.345.

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

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

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

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

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

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

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

2.1.40 FQHC Encounter Rate – The rate established by the Department to reimburse Federally Qualified Health Centers.

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

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

2.1.43 Health Neighborhood – A network of Medicaid providers ranging from specialists, hospitals, oral health providers, LTSS providers, home health care agencies, ancillary providers, and state-supported public health and social service agencies that support Members' health and wellness.

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

2.1.45 Healthy Communities – A program that contracts with county agencies to perform outreach, system navigation, and education of Medicaid Members in explaining their benefits and helping them find providers and utilizing their benefits

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

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

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

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

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

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

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

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

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

2.1.55 Medically Necessary – Also called Medical Necessity, shall be defined as described in 10 CCR 2505-10 § 8.076.1.8.

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

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

2.1.58 Monthly Capitation Payment – A payment the State makes on a monthly basis to a Contractor on behalf of each Member enrolled in its plan under a contract and based on the actuarially sound capitation rate for the provision of services covered under the Contract.

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

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

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

2.1.62 Offeror – Any individual or entity that submits a proposal, or intends to submit a proposal, in response to this solicitation.

2.1.63 Operational Start Date – The date that the Department authorizes the Contractor to begin fulfilling its obligations under the Contract.

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

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

2.1.66 Primary Care Alternative Payment Methodology (Primary Care APM) – A Department initiative to transition primary care provider reimbursement from one based on volume to one based on value.

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

2.1.68 Protected Health Information (PHI) – Any information about health status, provision of health care, or payment for health care that can be linked to a specific individual.

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

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

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

2.1.72 Primary Care Case Management Entity (PCCM Entity) – An organization that provides any of the following functions, in addition to PCCM services, for the state: provision of intensive telephonic or face-to-face case management; development of enrollee care plans; execution of contracts with and/or oversight responsibilities for the activities of fee-for-service providers in the Fee-for-Service program; provision of payments to Fee-for-Service providers on behalf of the state; provision of enrollee outreach and education activities; operation of a customer service call center; review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; coordination with behavioral health systems/providers; coordination with long-term services and supports systems/providers as defined in 42 C.F.R. § 438.2.

2.1.73 Primary Care Case Manager – A physician, a physician group practice, and if elected by the state, a physician assistant, nurse practitioner, or certified nurse-midwife as defined in 42 C.F.R. § 438.2.

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

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

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

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

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

2.1.79 Regional Accountable Entity (RAE) – A single regional entity responsible for the duties currently performed by Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs).

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

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

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

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

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

2.1.85 Tagline – A short statement written in a non-English language that indicates the availability of language assistance services free of charge as defined in 42 C.F.R. § 92.4.

2.1.86 Team-based Care – An approach that enables all clinical and non-clinical staff members within a practice to work collaboratively and to the full extent of their training, experience, and qualifications to deliver comprehensive care and support services to Members.

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

2.1.88 Urban County – A county in the Contractor's service area with a total population equal to or greater than 100,000 people.

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

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

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

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

2.1.93 Wraparound Care Coordination – An evidence-based model of Care Coordination that assists children and youth with significant mental health conditions and their family/caregiver with accessing health, education, social, and other services to meet the needs and objectives of the family.

SECTION 3.0 BACKGROUND INFORMATION

3.1 THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

3.1.1 The Department serves as the Medicaid Single State Agency. The Department develops and implements policy and financing for Medicaid and the Children's Health Insurance Program, called Child Health Plan *Plus* (CHP+) in Colorado, as well as a variety of other health care programs for Coloradans who qualify. For more information about the Department, visit www.Colorado.gov/HCPF.

3.1.2 The Department is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (United States Code [U.S.C.] Title 42 Sections 1320d through 1320d-8 [42 U.S.C. §§1320d – 1320d-8]) and its implementing regulations.

3.1.3 The Department operates the Colorado Medicaid Program, known as Health First Colorado, in accordance with the Colorado Medical Assistance Act (Section 25.5-4-104, *et seq.*, C.R.S.) and Title XIX of the Social Security Act. Colorado Medicaid is annually funded from appropriations authorized by the Colorado General Assembly and matched by federal funds.

3.2 PROJECT BACKGROUND

3.2.1 Colorado Medicaid Program History

3.2.1.1 Colorado Medicaid serves 1.33 million people and has an annual budget of $9.1 billion. The Department's mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. In the past five years, eligibility for Medicaid has expanded to include more children, pregnant women, parents and low-income adults. Medicaid enrollment increased from 588,925 in June 2011 to 1.33 million as of June 2016. Colorado chose to expand eligibility in advance of the Affordable Care Act and further expanded eligibility under the Affordable Care Act.

3.2.1.2 Individuals and families served by Colorado Medicaid, in large part, have complex health needs either because of life circumstances or a disability. Research has demonstrated that individuals served by Medicaid face significant barriers to better health and that individuals enrolled in Medicaid report poorer health compared to others in our state.

3.2.1.3 To meet the unique needs of those we serve, the Department has a long history of innovation and service to improve access, health care quality, and the health of its Clients. In addition, the Department works collaboratively with a very engaged community of Clients, providers, stakeholders, advocacy organizations, Community organizations, foundations, and legislators.

3.2.1.4 Currently, Colorado Medicaid Clients are primarily served through three major programs: the Accountable Care Collaborative Program (Program), Community Behavioral Health Services Program, and Long-Term Services and Supports (LTSS). Moving into the future, the Department intends to build on the successes of each program while also seeking to integrate these programs to better serve Clients and to effectively utilize state resources.

3.2.2 Health Care Reform in Colorado

3.2.2.1 In 2007, the State of Colorado embarked on a journey to improve Coloradans' access to cost-effective, high-quality health care services. The Blue Ribbon Commission for Health Care Reform (the Commission) assessed a variety of health care reform models in Colorado. After months of careful deliberation and discussion with stakeholders, constituents, legislators and executive officials, the Commission presented a comprehensive report in 2007 that provided a blueprint for health care reform in Colorado. Drawing upon the Commission's recommendations, the administration proposed a series of legislative initiatives referred to as the "Building Blocks to Health Care Reform." During the 2008 legislative session, the legislature passed all of the initiatives. The new legislation expanded children's health care coverage, increased reimbursement for providers, improved efficiencies in private and public health insurance programs, increased transparency and accountability across the health coverage system and identified further strategies to expand access to cost-effective, high-quality health care.

3.2.2.2 Two of the reform efforts were the Medicaid Value-Based Care Coordination Initiative (now known as the Accountable Care Collaborative Program) and the Colorado Health Care Affordability Act. The Department worked simultaneously on these efforts. The Department submitted a formal budget action for the Accountable Care Collaborative Program on November 3, 2008, and in April 2009, the Colorado Health Care Affordability Act (Colorado House Bill 09-1293) became law. The legislation authorized the Department to generate revenue through a hospital provider fee and draw down federal matching funds. A portion of the fees would be used to provide coverage to additional uninsured Coloradans and make health care more affordable by reducing uncompensated care and cost-shifting, without costing taxpayers or businesses more in taxes. Through this legislation, at least 100,000 more Coloradans became eligible to apply for medical assistance programs.

3.2.2.3 The passage of the Colorado Health Care Affordability Act, coupled with the unprecedented growth in Medicaid caseload due to the economic recession, reinforced the need for the Department to re-invent and innovate every aspect of its physical, behavioral and long term services and supports programs. The passage of the Patient Protection and Affordable Care Act enabled the Department to make significant changes to the way health care services were delivered to Medicaid Clients in order to maximize their health, functioning and independence. Over the past seven years, the Department has:

3.2.2.3.1 Implemented and expanded the Accountable Care Collaborative to more than one million Medicaid Members, resulting in improved health and more coordinated care.

3.2.2.3.2 Enhanced the Community Behavioral Health Services Program by adding substance use disorder services and increasing the program's focus on recovery and resiliency and trauma-informed care.

3.2.2.3.3 Created the Office of Community Living, improved programs using person- and family-centered approaches, and increased the number of Clients served in the community instead of institutions.

3.2.3 The Accountable Care Collaborative Program

3.2.3.1 The Accountable Care Collaborative Program is the core of the state's Medicaid program. It promotes improved health for Members by delivering care in an increasingly seamless way. The Accountable Care Collaborative works on the principle that coordinated care, with needed Community supports, is the best, most efficient way to deliver care to individuals. It is easier for Members and providers to navigate and it makes smarter use of every dollar spent.

3.2.3.2 The Program began as a managed Fee-for-Service model operated under a State Plan Amendment approved by the Centers for Medicare & Medicaid Services (CMS). It functions as a Primary Care Case Management (PCCM) model following the applicable federal requirements in 42 C.F.R. § 438. Prior to the Program, Medicaid Clients received their physical health services through an unmanaged Fee-for-Service approach.

3.2.3.3 The Program represents an innovative way to accomplish the Department's goals for Medicaid reform. It differs from a capitated managed care program by investing directly in Community infrastructure to support care teams and Care Coordination. It also creates aligned incentives to measurably improve Client health and reduce avoidable health care costs. The Program makes the people and organizations that actually provide care accountable for the quality, outcomes and the cost of that care. The fundamental premise of the Program is that regional communities are in the best position to make the changes that will cost-effectively optimize the health and quality of care for all Members. These regional communities are also best positioned to identify and meet Member needs and deliver efficient health care by assertively addressing unwarranted variation in practice patterns, misincentives from a volume-based payment system, and avoidable excess costs from fragmented care, while also promoting evidence-guided, shared decision making.

3.2.3.4 The Program provides the framework in which other health care initiatives, such as medical homes, health information technology and payment reform, can thrive as they better serve Members and create value. It is a hybrid model, adding the characteristics of an Accountable Care Organization to the PCCM model. Certain fundamental Accountable Care Organization characteristics are essential to the success of the Program. These characteristics include understanding Members' health and social needs, managing and integrating the continuum of care across different settings, including primary care, inpatient care and post-acute care; having enough Members to support comprehensive performance measurement; being capable of prospectively planning budget and resource needs; and having the ability to develop and organize provider networks.

3.2.3.5 The four initial goals of the Accountable Care Collaborative Program were to:

3.2.3.5.1 Expand access to comprehensive primary care

3.2.3.5.2 Ensure access to a focal point of care (i.e., Medical Home) for all Members

3.2.3.5.3 Ensure a positive Member and provider experience

3.2.3.5.4 Apply an unprecedented level of statewide data and analytics functionality

3.2.3.6 To achieve these goals, the Accountable Care Collaborative was comprised of three key components:

3.2.3.6.1 Regional Care Collaborative Organizations (RCCOs) are responsible for ensuring accountable care by developing a formal contracted network of primary care Medical Homes and an informal network of specialists and ancillary providers.

3.2.3.6.2 Primary Care Medical Providers (PCMPs) serve as the Medical Home for Members, providing whole-person, coordinated, and culturally competent care.

3.2.3.6.3 Statewide Data and Analytics Contractor (SDAC) provides operational support and data (via a web-based provider portal) to the Department, RCCO staff, and PCMPs to support program functions.

3.2.3.7 The state was divided into seven geographic regions with each region served by one RCCO. In the first contract period, five vendors served the seven regions, as three regions were awarded to one vendor. Program Members were assigned to a region and RCCO based upon their county of residence.

3.2.3.8 The Program has demonstrated improved health, reduced costs, and improved service utilization patterns. Members who have been in the Program for longer than six months are more likely to seek and receive preventive services and follow-up care, and less likely to receive services at an emergency room, receive high-cost imaging services, or be re-admitted to the hospital. Financial analysis indicates the Program avoided Member medical costs of $205 million, with net costs avoided of $61 million in FY 2015-16, and total cumulative savings of $139 million since the program began.

3.2.3.9 The Program is designed to be iterative. The first phase of the program was primarily focused on connecting Members to primary care services. Over the course of the Program, it evolved considerably to:

3.2.3.9.1 Expand enrollment from 500 Members to over one million Members in the first five years of the Program's operation

3.2.3.9.2 Connect more Coloradans to a Medical Home

3.2.3.9.3 Increase coordination of care between systems

3.2.3.9.4 Enhance PCMP standards to align with national patient-centered Medical Home standards

3.2.3.9.5 Evolve payment to reflect the iterative nature of the program and incent greater value

3.2.3.9.6 Increase coordination with LTSS by enrolling approximately 30,000 full benefit Medicare-Medicaid enrollees into the Program.

3.2.4 Community Behavioral Health Services Program

3.2.4.1 The Community Behavioral Health Services Program is a statewide program that provides comprehensive mental health and substance use disorder services to individuals enrolled in Medicaid. The program is operated under a federal 1915(b) waiver and administered by capitated managed care entities known as Behavioral Health Organizations (BHOs). Under this waiver, BHOs provide State Plan services (available to all Medicaid Members) as well as certain community-based services, known as 1915(b)(3) or "alternative" services. These services include respite, clubhouse/drop-in services, Assertive Community Treatment, and other non-medical services, all of which are provided in the least restrictive and most cost-effective manner in order to best use available funding. Proactively providing a broad array of supportive services in the community reduces the need for other high-cost services.

3.2.4.2 The program started as a pilot in 1995 and eventually expanded statewide. The program offers an array of services, and has been credited with directly decreasing the length and number of psychiatric hospitalizations. It has been recognized nationally as a model for serious and persistent mental illness and serious emotional disturbance as well as for shortening overall recovery time, increasing Client resilience and dealing with trauma-related behavioral health complications.

3.2.4.3 For the Community Behavioral Health Services Program, the state is divided into five (5) geographic regions with each region served by one BHO. There are currently four BHOs serving the five geographic service areas as two regions were awarded to one vendor. Medicaid Clients were assigned to a region and BHO based upon their county of residence.

3.2.4.4 The program has a long history in Colorado and has evolved significantly over the past 21 years:

3.2.4.4.1 Expanded the Community Behavioral Health Services Program in FY 2013-14 to include an outpatient substance use disorder treatment, increasing access to these services

3.2.4.4.2 Developed more than 400 sites across Colorado at which behavioral and physical care are integrated, thereby improving access to behavioral health services

3.2.4.4.3 Increased coordination of care for specialty populations, including children, adolescents and their families who are involved in the Child Welfare system

3.2.4.4.4 Evolved payment to incent greater value and improve Client screening, assessment and engagement

3.2.4.4.5 Developed trauma-informed and trauma-specific treatment interventions to address underlying behavioral health issues

3.2.5 Long Term Services and Supports (LTSS)

3.2.5.1 Colorado's system of Long-Term Services and Supports (LTSS) provides comprehensive services to people with many types of long-term care needs, including those with physical disabilities, serious mental health needs, and developmental and/or intellectual disabilities. The LTSS system works to support Clients in the least-restrictive settings possible. Long-Term Services and Supports are generally delivered in home and community based settings, nursing facilities or hospitals. The Home and Community Based Services (HCBS) system is operated through 11 individual waivers under 1915(c) authority from the Centers for Medicare and Medicaid Services (CMS). Services and supports associated with HCBS waivers include but are not limited to, personal care services, access to alternative care facilities, home modification, adult day programs, non-medical transportation and medication monitoring. To be considered for waiver services, a Client must meet financial and functional eligibility and program targeting criteria. HCBS waiver services are provided to individuals who, but for the provision of waiver services, would require the level of care provided in a nursing facility, hospital, or an intermediate care facility for individuals with intellectual disabilities.

3.2.5.2 In Colorado, most people access the LTSS system through two types of entities: Single Entry Points (SEPs) and Community Centered Boards (CCBs). SEPs and CCBs, in addition to three private agencies, act as the case management agencies for LTSS Clients receiving HCBS. Case management duties include level-of-care functional assessment, service plan development, referral, monitoring and remediation of Grievances and issues related to the provision of LTSS.

3.2.5.3 SEPs predominately serve as the entry point and Case Management Agency for older individuals, adults with mental health needs, individuals with traumatic brain or spinal cord injuries, and children with life-limiting illnesses. CCBs predominately serve as the entry point and Case Management Agency for individuals with intellectual and/or developmental disabilities and children with autism. Private case management entities, SEPs and CCBs can provide case management services for children with special health care needs through different waivers. There are 24 SEPs and 20 CCBs throughout the state.

3.2.5.4 Colorado’s system of LTSS has achieved important accomplishments, including:

3.2.5.4.1 Maintained a high level of LTSS Clients living in the community.

3.2.5.4.2 Transitioned 203 individuals from long-term care facilities to community living between April 2013 and September 2016 through the Colorado Choice Transitions Program.

3.2.5.4.3 Developed a pilot program to test the No Wrong Door model to streamline access to LTSS.

3.2.5.4.4 Increased participation in the Supported Employment Benefit from 1,120 in January 2011 to 2,327 in June 2016.

3.2.5.4.5 Created the Community Living Quality Improvement Committee to help shape a robust quality improvement process.

3.2.5.4.6 Conducted Person-Centered Thinking training with over 2,100 families, case managers and service providers across the state to help reshape how LTSS are provided.

3.2.5.4.7 Developed a plan for implementing conflict-free case management, including allowing Clients to eventually choose their own Case Management Agency.

3.3 NEXT ITERATION OF THE ACCOUNTABLE CARE COLLABORATIVE PROGRAM

3.3.1 Over the last five years the Accountable Care Collaborative has shown progress in creating a health care delivery program that improves health outcomes, better manages care and is a smarter use of resources. The Program was designed with a long-term vision in mind, and the understanding that to meet Members' complex health needs, delivery system change must be iterative to keep up with an evolving health care system. One important improvement will be to continue to more toward more coordinated and integrated care that increasingly rewards improved health outcomes.

3.3.2 The next phase of the Accountable Care Collaborative Program begins in July 2018. The Accountable Care Collaborative Program will build upon its first seven years and advance the Department's goals to improve Member health and life outcomes and to use state resources wisely. To achieve these goals, the Program will focus on the following objectives:

3.3.2.1 Join physical and behavioral health under one accountable entity

3.3.2.2 Strengthen coordination of services by advancing Team-based Care and Health Neighborhoods

3.3.2.3 Promote Member choice and engagement

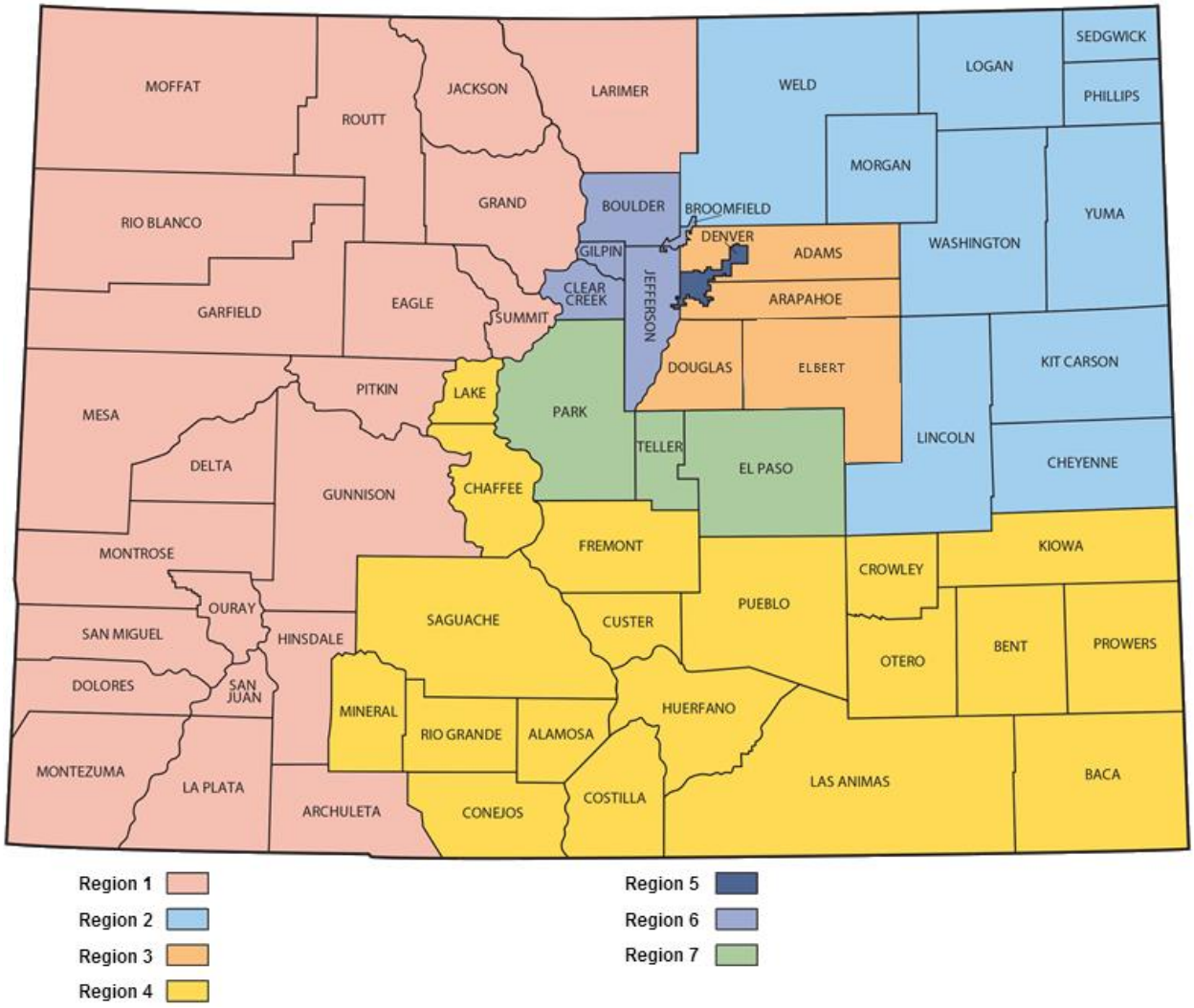
3.3.2.4 Pay providers for the increased value they deliver

3.3.2.5 Ensure greater accountability and transparency

3.3.3 One entity, the Regional Accountable Entity (RAE), will be responsible for promoting physical and behavioral health and the previous duties originally contracted by the Regional Care Collaborative Organizations and Behavioral Health Organizations in their region. The RAE will use this expanded scope to promote the population's health and functioning, coordinate care across disparate providers, interface with LTSS providers, and collaborate with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex Client needs that span multiple agencies and jurisdictions. The RAE will manage a network of primary care physical health providers and specialty behavioral health providers to ensure access to appropriate care for Medicaid Members. A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to Members. Having one entity will improve the Member experience by creating one point of contact and clear accountability for treating the whole person.

3.3.4 The state will continue to be divided into seven regions to continue to promote innovation, flexibility and local ownership of the public health and health care delivery system.

Regional Map for the Next Iteration of the Accountable Care Collaborative Program



3.3.5 Clients will be automatically enrolled as Members in the Program through mandatory enrollment and immediately connected with a Primary Care Medical Provider (PCMP). A PCMP must be a medical practitioner with a focus on primary care (family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology). Using either a claims-based assignment methodology or a Client choice-based attribution methodology, the Department will assign or attribute Clients to a PCMP. Based on the PCMP's geographic location, the PCMP Practice Site will be contracted with only one RAE. The geographic location of the Member's assigned/attributed PCMP will determine the Client's enrollment to a RAE. Members will be able to choose a PCMP at any time through the Department's enrollment broker.

3.3.6 The Accountable Care Collaborative Program will strengthen the PCMP network and the relationship between the RAE and PCMPs. RAEs will be given greater latitude to contract with practices that meet a set of basic minimum requirements that maintain the Department's commitment to enhancing the level of Medical Home standards. PCMPs will be encouraged and supported in leveraging all staff to the greatest extent possible to build Team-based Care.

3.3.7 The RAE will administer the Department's Capitated Behavioral Health Benefit to promote optimized mental health and wellness for all Members and to ensure delivery of Medically Necessary mental health and substance use disorder services. Addressing the community mental health needs of over 600,000 children, 100,000 pregnant women, and 500,000 adults is of prime importance to the Department so that emotional, behavioral, social and intellectual well-being potentials are achieved. The Department recognizes the RAE will contract statewide with a range of specialty behavioral health providers in order to deliver the full continuum of State Plan and 1915(b)(3) Services for mental health, substance use disorders and co-occurring conditions.

3.3.8 In addition, the RAE will have responsibility for ensuring timely and appropriate access to Medically Necessary services offered by the full range of Medicaid providers in the Health Neighborhood, including specialty, hospital, and home-based care, to meet the health and functioning needs of Members. The RAE will develop infrastructure that supports coordination between Network Providers and the Health Neighborhood, including: streamlining referral processes, improving communications among providers, clarifying roles and responsibilities of providers, and increasing the number of specialty care providers enrolled in Medicaid and actively treating Members. The RAEs will support provider access and utilization of tools and resources that will enable them to serve Members with complex conditions, obtain brief specialty consults, and make appropriate, timely, and coordinated referrals for Members requiring more intensive specialty care. The Department recognizes the vital role that all its providers offer to Members. For example, a Community pharmacist, home health worker or personal aide will generally see a Member more often than the PCMP. These providers can also play a role in the RAE's health promotion activities. The RAE can help strengthen the Health Neighborhood so that non-PCMP assessments inform subsequent interactions with Members.

3.3.9 The Department will continue to selectively contract with one Contractor for a region as opposed to multiple contractors within a region. One of many reasons for this decision is based on the recognition that an individual and region's health is impacted by many conditions and services beyond just clinical services. The RAE will develop mechanisms to engage Community partners within the RAE's region for population health and non-medical Community services. The RAE can invest in regional approaches to low-income population health without "Member plan switching" concerns. The Department recognizes that sizable percentages of the population will move off of Medicaid and wishes those Members to be healthier when they depart. The Department recognizes that there is also a sizable percentage for whom Medicaid will be a long-term payer. A regional model allows the RAE to promote Community and infrastructure approaches to creating a healthy culture and environment. The RAE can leverage these partnerships in order to link Members to appropriate Community organizations and resources. The RAEs will act as the Department's regional agent to advance multiple initiatives to promote pathways that help Members reach their full potential and address the Colorado's 10 Winnable Battles, which disproportionately impact low income communities and can be most effectively combatted in childhood.

3.3.10 In order to maximize impact and minimize redundancies, the Program will focus on greater coordination with the Colorado Departments of Human Services, Public Health and Environment, and Corrections, as well as initiatives such as Comprehensive Primary Care Plus (CPC+), State Innovation Model (SIM), Delivery System Reform Incentive Payment (DSRIP) program for hospitals, and the Colorado Opportunity Project. The RAE will play key regional roles in these initiatives as they are well aligned with the Accountable Care Collaborative's goals.

3.3.11 At the highest level, the next phase of the Accountable Care Collaborative aims to achieve the following:

3.3.11.1 Members will have their medical and behavioral health care needs met and receive Community supports in a seamless way.

3.3.11.2 Members and providers navigating the system will find it easier to use, and providers will be further incented to make improved outcomes their highest priority when treating and supporting Members.

3.3.11.3 Appropriate use of medical care will be the norm as overuse of some forms of care will continue to drop, ensuring that resources are used to their highest good in an efficient and effective system of care.

3.3.12 Population Health Management and Care Coordination Services

3.3.12.1 One of the objectives of the Program is strengthening coordination of services by advancing Team-based Care and Health Neighborhoods. Care Coordination provides a person- and family-centered approach to facilitate the appropriate delivery of physical health, behavioral health, LTSS, specialty care, ancillary services, oral health and other social services that support Member health and well-being. Ideally, Care Coordination will be provided face to face by individuals with strong ties to the Community who can develop ongoing relationships with Members.

3.3.12.2 Once a Client is enrolled in the Program, the Department will conduct a brief Health Needs Survey through PEAK and/or the Department's Enrollment Broker. The Health Needs Survey will be used to help PCMPs and RAEs identify a Member and family's potential immediate needs.

3.3.12.3 The RAE will be required to develop a clear population health management strategy fully aligned with other state health initiatives, particularly Colorado's 10 Winnable Battles and State of Health reports. In order to achieve Colorado's aim to be the healthiest state, the state has developed a life stage model that recognizes that interventions and plans vary throughout one's life. Health equity efforts can only be successful if particular focus is made on low-income populations who bear the brunt of health disparities and inequities. The RAEs will serve as the Department's regional leads for these efforts and their incentives will be, in part, tied to their progress against these goals.

3.3.12.4 The next iteration of the Accountable Care Collaborative Program will include efforts to improve the coordination and delivery of services for special populations: children involved with the child welfare system, individuals transitioning out of institutions and correctional facilities, and children at risk for out-of-home placement. As Members receiving LTSS already receive case management for a defined set of benefits, the RAE will collaborate with LTSS providers to design care coordination approaches that ensure a Member's complete health and wellness needs are being met and that reduces duplication of services and system fragmentation.

3.3.13 Integration of Primary Care and Behavioral Health Services

3.3.13.1 The Accountable Care Collaborative will support the integration of primary care and behavioral health by creating a single administrative entity (the RAE) overseeing both primary care and behavioral health services, as well as adjusting how services are reimbursed.

3.3.13.2 The Department will retain capitation for behavioral health services (referred to as the Capitated Behavioral Health Benefit) while making important changes to the behavioral health benefit.

3.3.13.2.1 The Department will rely less on the use of a covered diagnosis as a requirement for accessing Medically Necessary covered behavioral health services. Covered diagnoses will continue to be used to identify inpatient hospitalizations, emergency department visits, laboratory tests, and specific outpatient and alternative behavioral health services that will be reimbursed through the behavioral health benefit.

3.3.13.2.2 The Department will increase access to low acuity behavioral health interventions by encouraging the delivery of behavioral health within primary care settings. Low acuity behavioral health treatment delivered in primary care settings may be reimbursed Fee-for-Service for up to six (6) sessions per episode of care. These sessions will not require a covered behavioral health diagnosis. Additional sessions will require authorization from the RAE for reimbursement through the Capitated Behavioral Health Benefit.

3.3.13.3 The Department expects greater focus on innovative place-based community behavioral health education, skills training, and promotion of well-being across life stages and functional status. The RAE will be responsible for maintaining a comprehensive statewide network of specialty behavioral health providers capable of delivering the full range of covered services to support Members in improving their mental health and life outcomes. This includes providing services in multiple community-based settings, vocational services, clubhouse and drop-in centers, prevention and early intervention activities, support for Members transitioning to a new system of care or care environment, and other services that empower Members to reach their full potential.

3.3.14 Health Information Technology and Analytics

3.3.14.1 The Department's emerging Health Information Technology (HIT) ecosystem will enable greater data and information sharing among the Health Neighborhood.

3.3.14.2 The use of technology and data-driven decision making is integral to the operation and success of the Program. The combination of technology solutions provided by the Contractor and the Department will enable effective data and information sharing among Network Providers and the Health Neighborhood to improve Member health, measure performance and control costs.

3.3.14.3 The Department is implementing the Colorado interChange System, which will replace the previous Medicaid Management Information System (MMIS). Colorado interChange will offer enhanced functionality and capabilities that makes it easier for providers to use. The interChange system will also provide more functionality to implement different types of payment approaches.

3.3.14.4 The Department is implementing a business intelligence and data management system (BIDM) that collects, consolidates, and organizes data from multiple sources for reporting and business process analysis. The BIDM replaced the Statewide Data Analytics Contractor (SDAC) used for the first iteration of the Accountable Care Collaborative.

3.3.14.5 RAEs and Network Providers will be able to access the interChange and BIDM provider portals to check Member eligibility, view Member and population utilization and costs, access region-specific enrollment rosters, assess performance on Key Performance Indicators and quality-improvement activities, and generate ad hoc reports to support Program activities. These new technology resources will help to ensure clear lines of responsibility; facilitate coordinated care; promote data sharing; and ensure that the RAE is supporting the entire team.

3.3.15 Payment Innovation

3.3.15.1 The Accountable Care Collaborative was designed to help support the transition of payment within Medicaid to value-based models. The Department is committed to implementing innovative payment practices that reward efficiency, quality, coordination and health improvement and disincent duplication of services, overuse of low value services and fragmentation of care. Payment innovation within and supported by the Accountable Care Collaborative will align and complement state and federal alternative payment initiatives (e.g., Comprehensive Primary Care Plus, Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)). The Department will evolve payment by:

3.3.15.1.1 Reducing the amount of guaranteed administrative and service payments and linking a greater proportion of reimbursement to value

3.3.15.1.2 Creating flexible payments not tied to volume that fund non-traditional integrated, coordinated, comprehensive models of care.

3.3.15.1.3 Aligning provider rate-setting methodologies across provider types so that they are aligned and mutually-reinforcing (e.g., FQHCs, CMHCs, primary care)

3.3.15.1.4 Continuing to test innovative payment methodologies that improve health outcomes, Member satisfaction, and cost effectiveness as authorized in 25.5-5-415, C.R.S.

3.3.15.2 The RAEs will receive an administrative per-member per-month (PMPM) payment between $14.50 and $15.50, $4 of which will be withheld by the Department to fund pay-for-performance. The PMPM will support the RAE's health promotion activities within the region, the RAE's investments for the efficient, affordable delivery of care within the Health Neighborhood, and appropriate coordination of care for Members. In the next iteration of the Program, the Department is changing the way the PMPM is currently distributed. Instead of making a Medical Home payment directly to providers the Department will make the entire administrative payment to the RAE. This will enable the RAE to design flexible funding arrangements to support PCMPs and Health Neighborhood providers for participation in working to achieve the goals and objectives of the Accountable Care Collaborative. A minimum of 30% of the RAE's PMPM must be distributed to the PCMP network and Health Neighborhood, and RAEs must give PCMPs the option to receive a standard $2 PMPM. However, the RAE may work with providers to design different value-based payment arrangements that may exceed $2 PMPM.

3.3.15.3 The RAE will also receive a monthly Capitated Payment for each enrolled Member for the provision of the Capitated Behavioral Health Benefit. The RAE will assume comprehensive risk and take full responsibility for optimizing the mental health of Members and for providing and arranging for all covered inpatient and outpatient behavioral health services. The Department will tie the capitation payment to value in two ways.

3.3.15.3.1 Capitation Rate Setting: The capitation rate is built from an actuarially certified point estimate. CMS allows states to set individual contractor rates within a narrow (1.5%) range around the actuarially certified point estimate. In the next iteration, the Department will determine the RAE's rate within the available range based on the RAE's individual performance on identified metrics. All RAEs must meet or exceed several base standards or metrics in order for the rate to be set at the point estimate. If a RAE fails to meet the base standards, it will be paid at a rate below the point estimate. If a RAE achieves identified stretch performance goals, it will be paid at a rate higher than the point estimate.

3.3.15.3.2 Behavioral Health Incentive Payment: Subject to available funding, the Department will work with CMS to create an incentive program that will enable RAEs to earn up to a 4% incentive on top of their capitation for achieving key performance targets.

3.3.15.4 The Department will continue to withhold $4 from the RAE's administrative PMPM of between $14.50 and $15.50 to fund a pay-for-performance program that features three components.

3.3.15.4.1 Key Performance Indicators: the RAE will be able to earn performance payments based on meeting or exceeding targets for up to nine Key Performance Indicators (KPIs). The KPIs will consist primarily of a set of core measures defined by the Department, plus at least one measure that the RAE can choose from a list of options offered by the Department. As with the administrative PMPM, the RAE will have responsibility for sharing incentive payments with providers in a way that furthers the goals and objectives of the program.

3.3.15.4.2 Flexible Funding Pool: This pool will be created from any monies not distributed for KPIs and will be used to reinforce and align evolving program goals. The current Accountable Care Collaborative has utilized a similar pool of funding to increase payment for PCMPs that meet enhanced Medical Home standards, to support practices participating in the State Innovation Model, and to focus vendor attention on priority program outcomes. The Department will distribute monies from the Flexible Funding Pool in a similar manner for the next iteration. For example, the Department may distribute funds based on improving performance on a priority goal identified by the Department, or it may incentivize provider participation in new state or federal initiatives that are aligned with the Accountable Care Collaborative.

3.3.15.4.3 Public Reporting: The Department is committed to transparent reporting of vendor performance on key health and cost measures. Public reporting will be comprised of two components: 1) reporting of HEDIS and other clinical measures that align with SIM, CPC+, and other state and federal initiatives; and 2) reporting of broader public health type metrics where the RAE and provider play a critical but perhaps not determinative role in affecting change. Obesity rates, suicide rates and passive tobacco exposure are all examples of public health measures that RAEs can influence. While initially the Department will not reimburse performance on these measures directly, the Department will track progress on these measures to guide the evolution of the program.

3.3.15.5 Fee-for-Service Payment Innovation

3.3.15.5.1 In addition to changing payments within the Accountable Care Collaborative, the Department will be transforming how it reimburses primary care services through the Primary Care Alternative Payment Model (Primary Care APM). Primary Care providers that leverage Team-based Care practices, care management activities, Member engagement tools, and quality improvement strategies to deliver more efficient, cost effective care and to improve Member health will have an opportunity to earn a higher reimbursement rate.

3.3.15.5.2 These reforms will align with the Department's FQHC payment reform as well as various CMS-sponsored payment initiatives, such as the State Innovation Model and Comprehensive Primary Care Plus. The RAEs will have a key administrative role to assess and certify PCMPs for participation in the Primary Care APM, and to support providers in understanding, preparing for, and participating in the Primary Care APM.

3.3.15.5.2.1 The Department's Primary Care APM will feature two separate payment models for a core set of identified primary care codes.

3.3.15.5.2.1.1 Track One Primary Care APM: ACC PCMPs that are certified by the RAE as meeting certain criteria will receive higher reimbursement for a core set of primary care codes.

3.3.15.5.2.1.2 Track Two Primary Care APM: Primary care providers who apply and are accepted to participate will be able to transition a significant portion of their reimbursement to a prospective payment that provides a guaranteed revenue stream to help providers shift from delivering volume-based care to more value-based practices. The remainder of their reimbursement will be based on billing a core set of primary care codes.

3.3.15.6 Testing Payment Reform Models

House Bill 12-1281 of the Second Regular Session of the 68th General Assembly was passed in 2012, creating the Medicaid Payment Reform and Innovation Pilot Program (25.5-5-415, C.R.S), which allows the Department to accept proposals for innovative payment reform pilots that demonstrate new ways of paying for improved Client outcomes while reducing costs in the Accountable Care Collaborative. The Department has tested two specific payment reform models: a full-risk, comprehensive physical health payment reform program for adults operating in six counties on the western slope and a primary care capitation program operating in the Denver metropolitan area.

3.3.15.6.1 This next iteration of the Accountable Care Collaborative will allow a broader application of the primary care capitation program tested under 25.5-5-415, C.R.S., through the Track Two Primary Care APM. This will allow qualified primary care providers to assume increasing levels of risk for a primary care benefit and accountability for improved financial and health outcomes.

3.3.15.6.2 The Department will incorporate lessons learned from the current models and continue to work with RAEs to test innovative payment models developed under 25.5-5-415, C.R.S. However, the Department is not able to guarantee continuation of existing contracts under 25.5-5-415, C.R.S, as they are developed under individualized CMS authority tied to a particular awardee, not a region.

3.3.16 Additional RAE Responsibilities

3.3.16.1 As the Accountable Care Collaborative is an iterative program, the Department continues to explore ways to evolve the program and implement activities to improve Member health and life outcomes. The Department is currently working on three additional areas of responsibility that may be incorporated into the RAE contract: Wraparound Program, Pre-Admission Screening and Resident Review (PASRR), and brokering of case management. Each of these responsibilities require further development and state and federal approvals before they can be incorporated into the Work. All three programs have distinct funding.

3.3.16.2 Wraparound Program

3.3.16.2.1 The Department is working with the Colorado Department of Human Services and CMS to design and implement the Wraparound Program as part of an intensive Systems of Care to improve the health, well-being and functioning of children and youth with significant mental health conditions who are at risk for out-of-home placement, as well as their families and caregivers. The Systems of Care is a comprehensive, community-based program to ensure that children and youth with significant mental health conditions and their families/caregivers receive services they need for success in home, school and Community. This system is designed to improve the health, well-being, and functioning of these children/youth and their families/caregivers and seeks to reduce potentially-preventable emergency room, inpatient, and residential child care facilities utilization.

3.3.16.2.2 The state's System of Care is built on the evidence-based model detailed within the book *Building Systems of Care: A Primer* (2010).

3.3.16.2.3 The core components of the System of Care are:

3.3.16.2.3.1 Wraparound Care Coordination (Wraparound). An evidence-based model of Care Coordination that assists the child and the family/caregiver to access behavioral health, medical and oral, social, educational, developmental and other services to meet the needs and the objectives of the family.

3.3.16.2.3.2 Parent/Caregiver Peer Support. A program that provides a structured, one-to-one, strength-based relationship between a parent/caregiver and a trained peer parent/caregiver of a child or youth with special needs.

3.3.16.2.3.3 Intensive In-home Therapy Services. A combination of State Plan benefits and other services.

3.3.16.2.3.4 Flexible Funds. Funding that is made available to assist the child/youth and family/caregiver with non-medical needs that nonetheless impact the health, functioning and well-being of the child or family.

3.3.16.2.4 For the next iteration of the Accountable Care Collaborative, the Department may require the RAEs to oversee the provision of a Wraparound Program that consists of both the Wraparound Care Coordination and parent/caregiver peer support components. The Contractor shall implement the Wraparound Program when requested by the Department and participate in the evolution of the Wraparound Program.

3.3.16.3 Pre-Admission Screening and Resident Review (PASRR)

3.3.16.3.1 The Pre-Admission Screening and Resident Review program (PASRR) is a protection and advocacy program that ensures individuals who have major mental illness and/or an intellectual or developmental disability receive the appropriate treatment in the appropriate setting for the appropriate amount of time. PASRR is a federally mandated program created in 1987 through the Omnibus Budget Reconciliation Act (OBRA). It is designed to determine Medical Necessity for nursing facility placement and need for specialized services for individuals with mental illness and/or an intellectual or developmental disability.

3.3.16.3.2 PASRR has three goals for any individual being admitted to a Medicaid certified nursing facility: 1) to identify individuals with mental illness and/or an intellectual or developmental disability; 2) to ensure these individuals are placed appropriately, whether in the community or in a nursing facility; and 3) to ensure that these individuals receive the services they require for their mental illness or their intellectual or developmental disability diagnosis in whatever setting they reside.

3.3.16.3.3 PASRR requires that individuals be assessed when they apply to a nursing facility (the Preadmission Screen, or PAS) and on a systematic basis after admission (the Resident Review, or RR, upon change in status or condition). There are three elements to PASRR.

3.3.16.3.3.1 Pre-Admission Screen (PAS) Level I is a preliminary screen completed by staff from nursing facilities, Single Entry Point agencies or hospital discharge planners for the purpose of indicating the possible presence of mental illness or intellectual or development disability for an individual seeking nursing facility admission.

3.3.16.3.3.2 PAS Level II is an in-depth evaluation completed by a trained assessor to confirm the presence of a mental illness or intellectual or developmental disability, determine the appropriate living situation, and identify what specialized services are needed, if any.

3.3.16.3.3.3 Resident Review is conducted on a systematic basis for Members residing in a nursing facility and whenever there is a change in a Member's condition that may affect their mental illness or intellectual/developmental disability status.

3.3.16.3.4 The Department may require the RAEs to manage the Colorado PASRR in accordance with state and federal statutes, rules and regulations. PASRR administration will include reviewing PAS Level I and II, conducting or coordinating the completion of Level II assessments, arranging specialized services, noticing Members and agencies about the PASRR outcomes, monitoring the quality of PASRR and participating in required trainings.

3.3.16.4 Brokering of Case Management

3.3.16.4.1 In Colorado, SEPs and CCBs, in addition to three private agencies, act as the case management agencies for LTSS Members receiving Home and Community Based services (HCBS).

3.3.16.4.2 In March 2014, CMS implemented regulation regarding person-centered service plan development. Part of this regulation requires states to separate case management from direct service delivery functions to eliminate conflict of interest for services provided under HCBS waivers. This rule addresses the conflict of interest that may arise when one entity is responsible for both performing case management functions and providing direct services. As a result of these federal regulations, Colorado's existing system for its HCBS waivers is no longer compliant. There are 20 Community Centered Boards (CCB) designated by statute to provide case management for three waivers for individuals with intellectual and developmental disabilities, and all 20 CCBs provide direct HCBS waiver services. In addition, the CCBs perform all eligibility determination for services for people with intellectual and developmental disabilities. Furthermore, the Single Entry Point agencies perform eligibility determination and case management for the eight other HCBS waivers in Colorado. Some of the Single Entry Point agencies also provide direct HCBS waiver services for people for whom they provide case management.

3.3.16.4.3 To continue receiving federal funding for the I/DD waivers, Colorado must come into compliance with the CMS conflict-free case management regulations. In accordance with Colorado House Bill 15-1318, which was passed in 2015 to create 25.5-6-409.3, C.R.S., the Department has created a plan for the delivery of conflict-free case management that complies with federal regulations, with input from CCBs, SEPs, and other stakeholders.

3.3.16.4.4 As part of the Department's efforts to create a conflict-free case management system, the RAE may be required to act as a neutral party to support Members in selecting the Case Management Agency that best meets their needs. The RAE will be responsible for brokering a case management network that maximizes choice. Agencies currently providing LTSS case management can continue to serve Members, if that is the Member's choice, and the RAE will honor local control.

3.3.17 Future Considerations

3.3.17.1 The Accountable Care Collaborative Program has and will continue to be iterative and evolve over time. The first contract of the Accountable Care Collaborative Program created a platform for future delivery system and payment reform efforts. The Department intends to continue to make changes to the Program that could alter the scope of the Program and the Contract resulting from this RFP.

3.3.17.2 Revisions to the Program that may require changes to the Work in this procurement and resulting Contract may include:

3.3.17.2.1 Implementation of alternative benefit packages within Colorado Medicaid as allowed through the Affordable Care Act.

3.3.17.2.2 Implementation of payment reform as authorized in 25.5-5-415, C.R.S.

3.3.17.2.3 Administration of the CHP+ or the incorporation of CHP+ members into the ACC.

3.3.17.2.4 Administration of the Dental Administrative Services Only contract.

3.3.17.2.5 Administration of the Non-Emergency Medical Transportation (NEMT) administrative contract and/or benefits.

3.3.17.2.6 Implementation of recommendations from the LTSS No Wrong Door pilot.

3.3.17.2.7 Inclusion of Case Management Agency and PASRR functions not already included in the Work.

3.3.17.2.8 Inclusion of new service bundles addressing social determinants of health.

3.3.17.2.9 Implementation of a statewide Member engagement incentive and/or wellness promotion program.

SECTION 4.0 OFFEROR'S EXPERIENCE

4.1 MANDATORY QUALIFICATIONS

4.1.1 Offeror's organization shall meet all mandatory qualification requirements in this section 4.1 to be considered for award of a contract from this solicitation.

4.1.2 The Offeror shall be licensed as either a:

4.1.2.1 Health Maintenance Organization (HMO) or

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

4.1.3 The Offeror shall attest to meeting the definition and requirements of a Primary Care Case Management Entity (PCCM Entity) set forth in 42 C.F.R. § 438.2.

4.1.4 The Offeror shall attest to meeting the definition and requirements of a Prepaid Inpatient Health Plan (PIHP) set forth in 42 C.F.R. § 438.2.

4.2 ORGANIZATIONAL EXPERIENCE

4.2.1 The Department has determined that it desires specific experience and skills for an Offeror to possess in order for the Offeror to be able to complete the Work efficiently while meeting the demands and deadlines of the Department.

4.2.2 The Department will evaluate the Offeror's experience and skills pertaining to the following:

4.2.2.1 Experience managing projects of similar size and scope to the Program described in this RFP.

4.2.2.2 Experience within the last ten (10) years providing, arranging for or otherwise being responsible for the delivery and coordination of comprehensive behavioral health and physical health care services spanning the continuum of care of outpatient and inpatient services.

4.2.2.3 Experience within the past five (5) years providing, arranging for or otherwise being responsible for the delivery and coordination of physical health care services spanning the continuum of care as an administrative services organization, Primary Care Case Manager Entity or similar evidence of performance of a non-capitated, physical health service contract.

4.2.2.4 Experience within the last five (5) years must have been serving Medicaid covered populations, including children, adults, older adults, Medicare and Medicaid Members, disabled, and individuals with multiple chronic, co-morbid conditions.

4.2.2.5 Experience within the last ten (10) years administering managed care with the infrastructure necessary to improve access to care, to build and manage a provider network, to pay claims, to monitor and evaluate provider and system performance, and to implement quality improvement initiatives.

4.2.2.6 Experience within the last ten (10) years managing financial risk for covered services.

SECTION 5.0 STATEMENT OF WORK

5.1 CONTRACTOR'S GENERAL REQUIREMENTS

5.1.1 The Department will contract with only one (1) organization per region, the Contractor, and will work solely with that organization with respect to all tasks and deliverables to be completed, services to be rendered and performance standards to be met.

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

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

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

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

5.1.6 Deliverables

5.1.6.1 All deliverables shall meet Department-approved format and content requirements. The Department will specify the number of copies and media for each deliverable.

5.1.6.2 Each deliverable will follow the deliverable submission process as follows:

5.1.6.2.1 The Contractor shall submit each deliverable to the Department for review and approval.

5.1.6.2.2 The Department will review the deliverable and may direct the Contractor to make changes to the deliverable. The Contractor shall make all changes within five (5) Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.

5.1.6.2.3 Changes the Department may direct include, but are not limited to, modifying portions of the deliverable, requiring new pages or portions of the deliverable, requiring resubmission of the deliverable or requiring inclusion of information that was left out of the deliverable.

5.1.6.2.4 The Department may also direct the Contractor to provide clarification or provide a walkthrough of each deliverable to assist the Department in its review. The Contractor shall provide the clarification or walkthrough as directed by the Department.

5.1.6.2.5 A deliverable shall be deemed accepted upon the Department's written notice to the Contractor of its acceptance.

5.1.6.3 The Contractor shall employ an internal quality control process to ensure that all deliverables, documents and calculations are complete, accurate, easy to understand and of high quality. The Contractor shall provide deliverables that, at a minimum, are responsive to the specific requirements for that deliverable, organized into a logical order, contain no spelling or grammatical errors, are formatted uniformly and contain accurate information and correct calculations. The Contractor shall retain all draft and marked-up documents and checklists utilized in reviewing deliverables for reference as directed by the Department.

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

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

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

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

5.1.6.7.1 Any deliverable described as an update of another deliverable is considered a version of the original deliverable for the purposes of this subsection.

5.1.7 Stated Deliverables and Performance Standards

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

5.1.8 Communication Requirements

5.1.8.1 Communication with the Department

5.1.8.1.1 The Contractor shall enable all Contractor staff to exchange documents and electronic files with the Department staff in formats compatible with the Department's systems. The Department currently uses Microsoft Office 2013 and/or Microsoft Office 365 for PC. If the Contractor uses a compatible program that is not the system used by the Department, then the Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.

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

5.1.8.1.2.1 An individual who is authorized to speak on the record regarding the work, the Contract or any issues that arise that are related to the work.

5.1.8.1.2.2 An individual who is responsible for any website or marketing related to the work.

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

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

5.1.8.1.3.1 The date the transmittal will be effective.

5.1.8.1.3.2 Direction to the Contractor regarding performance under the Contract.

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

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

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

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

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

5.1.8.1.3.7 If the Contractor receives conflicting transmittals, the Contractor shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, to obtain direction. If the Department does not provide direction otherwise, then the transmittal with the latest effective date shall control.

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

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

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

5.1.8.2 Communication with Providers and Other External Entities

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

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

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

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

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

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

5.1.8.2.3 The Contractor shall deliver the Communication Plan to the Department for review and integrate suggested changes into the final plan.

5.1.8.2.4 Once the Communication Plan is approved by the Department, the Contractor shall implement the Plan.

5.1.8.2.4.1 DELIVERABLE: Communication Plan

5.1.8.2.4.2 DUE: Within ten (10) business days after the Effective Date

5.1.8.2.4.3 The Contractor shall review its Communication Plan on an annual basis and determine if any changes are required to account for any changes in the work, in the Department's processes and procedures or in the Contractor's processes and procedures. The Contractor shall submit an Annual Communication Plan Update that contains all changes from the most recently approved prior Communication Plan, Annual Communication Plan Update or Interim Communication Plan Update or shall note that there were no changes.

5.1.8.2.4.4 DELIVERABLE: Annual Communication Plan Update

5.1.8.2.4.5 DUE: Annually, by July 31st of each year

5.1.8.2.4.6 The Department may request a change to the Communication Plan at any time to account for any changes in the work, in the Department's processes and procedures or in the Contractor's processes and procedures, or to address any communication related deficiencies determined by the Department. The Contractor shall modify the Communication Plan as directed by the Department and submit an Interim Communication Plan Update containing all changes directed by the Department.

5.1.8.2.4.7 DELIVERABLE: Interim Communication Plan Update

5.1.8.2.4.8 DUE: Within ten (10) Business Days following the receipt of the request from the Department, unless the Department allows for a longer time in writing.

5.1.8.2.4.9 The Contractor shall not engage in any non-routine communication with any Member, any provider, the media or the public without the prior written consent of the Department.

5.1.9 Business Continuity

5.1.9.1 The Contractor shall create a Business Continuity Plan that the Contractor will follow in order to continue operations after a disaster or a business interruption. The Business Continuity Plan shall include, but is not limited to, all of the following:

5.1.9.1.1 How the Contractor will replace staff that has been lost or become unavailable to avoid a business interruption so that the work is performed in accordance with the Contract.

5.1.9.1.2 How the Contractor will back up all information necessary to continue performing the work, so that no information is lost.

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

5.1.9.1.4 How the Contractor will minimize the effects of any Business Interruptions on Members.

5.1.9.1.5 How the Contractor will communicate with the Department during the business interruption and points of contact within the Contractor's organization the Department can contact in the event of a business interruption.

5.1.9.1.6 Planned long-term back-up facilities out of which the Contractor can continue operations after a disaster.

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

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

5.1.9.2.1 DELIVERABLE: Business Continuity Plan

5.1.9.2.2 DUE: Within ten (10) Business Days after the Effective Date.

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

5.1.9.3.1 DELIVERABLE: Updated Business Continuity Plan

5.1.9.3.2 DUE: Annually, by July 31 of each year.

5.1.9.4 In the event of any business interruption, the Contractor shall implement and comply with its most recently approved Business Continuity Plan or Updated Business Continuity Plan immediately after the Contractor becomes aware of the business interruption.

5.1.10 Federal Financial Participation Related Intellectual Property Ownership

5.1.10.1 In addition to the intellectual property ownership rights in the Contract, the following subsections describe the intellectual property ownership requirements that the Contractor shall meet during the term of the Contract in relation to federal financial participation.

5.1.10.2 To facilitate obtaining the desired amount of federal financial participation under 42 C.F.R. §433.112, the Department shall have all ownership rights, not superseded by other licensing restrictions, in all materials, programs, procedures, etc., designed, purchased, or developed by the Contractor and funded by the Department. The Contractor shall use contract funds to develop all necessary materials, programs, products, procedures, etc., and data and software to fulfill its obligations under the Contract. Department funding used in the development of these materials, programs, procedures, etc. shall be documented by the Contractor. The Department shall have all ownership rights in data and software, or modifications thereof and associated documentation and procedures designed and developed to produce any systems, programs reports and documentation and all other work products or documents created under the Contract. The Department shall have these ownership rights, regardless of whether the work product was developed by the Contractor or any Subcontractor for work product created in the performance of this Contract. The Department reserves, on behalf of itself, the Federal Department of Health and Human Services and its contractors, a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures. Such data and software includes, but is not limited to, the following:

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

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

5.1.10.2.3 All necessary data files.

5.1.10.2.4 User and operation manuals and other documentation.

5.1.10.2.5 System and program documentation in the form specified by the Department.

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

5.1.11 Performance Reviews

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

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

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

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

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

5.1.12 Renewal Options and Extensions

5.1.12.1 The Department may, within its sole discretion, choose to not exercise any renewal option in the Contract for any reason. If the Department chooses to not exercise an option, it may re-procure the performance of the work in its sole discretion.

5.1.12.2 The parties may amend the Contract to extend beyond seven (7) years, in accordance with the Colorado Procurement Code and its implementing rules, if the Department determines the extension is necessary to align the Contract with other Department contracts, to address state or federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the work.

5.1.12.2.1 In the event that the Contract is extended beyond seven (7) years, the annual maximum compensation for the Contract in any of those additional years shall not exceed the Contract maximum amount for the prior State Fiscal Year (SFY) plus the annual percent increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the Denver-Boulder-Greeley metropolitan area for the calendar year ending during that prior SFY. If the CPI-U for Denver-Boulder-Greeley is for some reason not available as specified in this subsection, the increase shall be equal to the percent increase in the CPI-U (U.S.) for the same period.

5.1.12.2.2 The limitation on the annual maximum compensation in section 5.1.12.2.1 shall not include increases made specifically as compensation for additional work added to the Contract.

5.1.13 Department System Access

5.1.13.1 In the event that the Contractor requires access to any Department computer system to complete the work, the Contractor shall have and maintain all hardware, software and interfaces necessary to access the system without requiring any modification to the Department's system. The Contractor shall follow all Department policies, processes and procedures necessary to gain access to the Department's systems.

5.2 PERSONNEL

5.2.1 The Contractor shall possess the organizational resources and commitment necessary to perform the work and successfully implement and operate the program in the awarded Region. Specifically, the Contractor shall:

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

5.2.1.2 Have a physical office located in the awarded Region.

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

5.2.2.1 The Contractor shall provide the Department with a final list of individuals assigned to the Contract.

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

5.2.3 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.

5.2.4 The Contractor shall obtain written approval from the Department for individuals proposed for assignment to Key Personnel positions prior to those individuals beginning the performance of any work under the Contract.

5.2.5 The Contractor shall not voluntarily change individuals in Key Personnel positions without the prior written approval of the Department. The Contractor shall supply the Department with the name(s), resume and references for any proposed replacement whenever there is a change to Key Personnel. Any individual replacing Key Personnel shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department.

5.2.6 In the event that any individual filling a Key Personnel position leaves employment with the Contractor, the Contractor shall propose a replacement person to the Department. The replacement person shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department. The Contractor shall submit a resume and the Key Personnel Approval Form for the Contractor's candidate for the position. The Department shall provide feedback on the candidate within five (5) business days of the Contractor's submission of the required information.

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

5.2.8 The Contractor shall appoint any new Key Personnel only after a candidate has been approved by the Department to fill a vacancy.

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

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

5.2.11 Personnel Availability

5.2.11.1 The Contractor shall ensure Key Personnel and Other Personnel assigned to the Contract are available for meetings with the Department during the Department's normal business hours, as determined by the Department. The Contractor shall also make these personnel available outside of the Department's normal business hours and on weekends with prior notice from the Department.

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

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

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

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

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

5.2.12 Key Personnel

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

5.2.12.1.1 Program Officer – 1.0 FTE. The Program Officer shall be a senior management position responsible for the following:

5.2.12.1.1.1 Serve as the Contractor's primary point of contact for the Contract and for Contract performance. The Program Officer shall work out of their office within the contracted region.

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

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

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

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

5.2.12.1.2 The Program Officer shall have the following qualifications:

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

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

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

5.2.12.1.3 Chief Financial Officer (CFO) – 1.0 FTE. The CFO shall be a senior management position accountable for the administrative, financial, and risk management operations of the organization, to include the development of a financial and operational strategy, metrics tied to that strategy, and the ongoing development and monitoring of control systems designed to preserve company assets and report accurate financial information.

5.2.12.1.3.1 The CFO shall be responsible for the following:

5.2.12.1.3.1.1 Effective implementation and oversight of the budget, accounting systems, financial and risk management operations for the organization, development of financial management strategy, including robust monitoring and reporting.

5.2.12.1.3.1.2 Ensuring financial compliance with federal and state laws and the requirements.

5.2.12.1.3.2 The CFO shall have the following qualifications:

5.2.12.1.3.2.1 Master's degree in accounting or business administration.

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

5.2.12.1.4 Chief Clinical Officer (CCO) – 1.0 FTE. The CCO shall be a senior management position responsible for defining the overall clinical vision for the organization and providing clinical direction to network management, quality improvement, utilization management and credentialing divisions. The position provides medical oversight, expertise and leadership to ensure the delivery of coordinated, cost-effective services and supports for Members. The position also participates in strategy development and the design and implementation of innovative clinical programs and interventions with the Health Neighborhood and Community.

5.2.12.1.4.1 The CCO shall have the following qualifications:

5.2.12.1.4.1.1 Be a physician licensed and registered in any state.

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

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

5.2.12.1.5 Quality Improvement Director – 1.0 FTE. The Quality Improvement Director shall be a management level position accountable for development and implementation of quality improvement programs, all aspects of measuring and assessing program outcomes; directing and coordinating all quality improvement activities; ensuring alignment with federal and state guidelines; and setting internal performance goals and objectives.

5.2.12.1.5.1 The Quality Improvement Director shall have the following qualifications:

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

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

5.2.12.1.5.1.3 Knowledge and Experience in the following areas:

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

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

5.2.12.1.5.1.3.3 Compliance and regulation enforcement.

5.2.12.1.6 Health Information Technology (HIT) and Data Director – 1.0. FTE.

5.2.12.1.6.1 The HIT and Data Director shall be responsible for facilitating data sharing among the Contractor, the state, and Network Providers; ensuring the implementation and operation of technological tools required to perform the Work; identifying opportunities to reduce redundancy in workflows and data systems; and assisting Network Providers to maximize the use of EHRs and Health Information Exchange.

5.2.12.1.6.2 The HIT and Data Director shall develop the organization's strategy and be accountable for operations related to the receipt and processing of:

5.2.12.1.6.2.1 Client enrollment spans

5.2.12.1.6.2.2 Capitation payments

5.2.12.1.6.2.3 Encounter data

5.2.12.1.6.2.4 Health needs survey information

5.2.12.1.6.2.5 Admission, discharge, and transfer data

5.2.12.1.6.2.6 BIDM data

5.2.12.1.6.3 The HIT and Data Director shall have the following qualifications:

5.2.12.1.6.3.1 Experience directing a health information technology program.

5.2.12.1.6.3.2 Experience supporting health care practices.

5.2.12.1.6.3.3 Expertise in health data analytics.

5.2.12.1.7 Utilization Management Director – 1.0 FTE

5.2.12.1.7.1 The Utilization Management Director shall be responsible for leading and developing the utilization management program and managing the medical review and authorization process. The Utilization Management Director shall oversee the medical appropriateness and necessity of services provided to Members, as well as analyze and monitor utilization trends, identify problem areas and recommend action plans for resolution.

5.2.12.1.7.2 The Utilization Management Director shall have the following qualifications:

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

5.2.12.1.7.2.2 Minimum of five years cumulative experience in utilization management and/or managed care.

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

5.2.13 Other Personnel Responsibilities

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

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

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

5.2.14 Subcontractors

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

5.2.14.2 The Contractor shall not subcontract more than forty percent (40%) of the total value of this contract.

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

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

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

5.2.15 Deliverables

5.2.15.1 DELIVERABLE: Final list of names of the individuals assigned to the Contract

5.2.15.1.1 DUE: Within five (5) Business Days following the Effective Date.

5.2.15.2 DELIVERABLE: Updated list of names of the individuals assigned to the Contract

5.2.15.2.1 DUE: Within five (5) Business Days following the Department's request for an update

5.2.15.3 DELIVERABLE: Organizational Chart.

5.2.15.3.1 DUE: Thirty (30) days after the Contract's Effective Date.

5.2.15.4 DELIVERABLE: Updated Organizational Chart.

5.2.15.4.1 DUE: Within five (5) Business Days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.

5.2.15.5 DELIVERABLE: Name(s) for the person(s) replacing anyone in a Key Personnel position during an interim change

5.2.15.5.1 DUE: At least five (5) Business Days prior to the change in Key Personnel

5.2.15.6 DELIVERABLE: Name(s), resume(s), and Key Personnel Clearance Form for the person(s) replacing anyone in a Key Personnel position who leaves employment with the Contractor

5.2.15.6.1 DUE: Within ten (10) Business Days following the Contractor's identification of a potential replacement.

5.2.15.7 DELIVERABLE: All current professional licensure and certification documentation as specified for Key Personnel or other personnel

5.2.15.7.1 DUE: Within five (5) Business Days of receipt of updated licensure or upon request by the Department.

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

5.2.15.8.1 DUE: No later than thirty (30) days prior to the Subcontractor beginning work or the effective date.

5.3 REGIONAL ACCOUNTABLE ENTITY

5.3.1 The Contractor shall be the single Regional Accountable Entity (RAE) responsible for administering the Accountable Care Collaborative Program within their region.

5.3.2 The Contractor shall perform all of the functions described in this Contract in compliance with all pertinent state and federal statutes, regulations and rules. The Program is administered under a single 1915(b) waiver that grants the Department the authority to operate the ACC under two managed care authorities: Primary Care Case Management Entity (PCCM Entity) and a Pre-paid Inpatient Health Plan (PIHP).

5.3.2.1 The Contractor shall administer the two managed care authorities as one integrated program.

5.4 MEMBER ENROLLMENT AND ATTRIBUTION

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

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

5.4.2.1 Qualified Medicare Beneficiary only (QMB-only)

5.4.2.2 Qualified Working Disabled Individuals (QWDI)

5.4.2.3 Qualified Individuals 1 (QI 1)

5.4.2.4 Special Low Income Medicare Beneficiaries (SLMB)

5.4.2.5 Undocumented immigrants

5.4.2.6 All individuals while determined presumptively eligible for Medicaid

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

5.4.3.1 The Contractor shall have systems capable of receiving and processing the 834 transaction generated by the interChange (MMIS).

5.4.3.2 The Contractor shall ensure that Network Providers supply services only to eligible Medicaid Members. The Contractor shall make it the responsibility of the Network Provider to verify that the individual receiving services covered under this Contract is Medicaid eligible on the date of service, whether the Contractor or the Department is responsible for reimbursement of the services provided, and whether the Contractor has authorized a referral or made special arrangements with a provider, when appropriate.

5.4.4 Enrollment into the Program is effective on the same day that a Member's Medicaid eligibility notification is received in interChange from the Colorado Benefit Management System (CBMS).

5.4.5 Members shall be enrolled with the Contractor based on the location of the PCMP Practice Site to which the Member is attributed (e.g., if a Member lives in Region 3, but is attributed to a PCMP Practice Site in Region 5, the Member will be enrolled to the Contractor in Region 5). The PCMP attribution effective date will be the same as the RAE enrollment date.

5.4.6 Members shall be automatically re-enrolled with the PCMP and RAE that was in effect at the time of their loss of Medicaid eligibility if there is a loss of Medicaid eligibility of two (2) months or less.

5.4.7 The Contractor shall not discriminate against individuals eligible to enroll in the Program on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs or disability, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs or disability. The Contractor shall not discriminate against individuals eligible to enroll in the Program on the basis of Member health status or need for health care services.

5.4.8 The Contractor shall accept all eligible Members that the Department enrolls in the order in which they are enrolled without restriction. The Department will enroll Members based on the following attribution process:

5.4.8.1 If a Member has previously chosen a PCMP within the Program, that attribution is retained and the Members will be enrolled into the RAE region where the PCMP Practice Site is located.

5.4.8.2 If a Member has not selected a PCMP previously, the Department will use the system assignment process outlined in Appendix F Enrollment and Attribution to attribute the Member to a PCMP. The Member will be enrolled into the RAE region where that PCMP Practice Site is located.

5.4.8.2.1 On a quarterly basis, the Department will review the attributions of Members who were attributed using the system assignment process. If a stronger PCMP relationship can be determined, using the Department's attribution methodology, the Member will be reattributed.

5.4.8.3 Members will be formally notified of their PCMP attribution and RAE enrollment through the Department's Enrollment Broker.

5.4.9 Members may select a different PCMP at any time through the Enrollment Broker or the interChange (MMIS) Member Portal.

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

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

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

5.4.10.1 The Contractor shall regularly compare this attribution list with Member claims activity to ensure accurate Member attribution. The Contractor shall follow up with Members who are seeking care from primary care providers other than the attributed PCMP to identify any barriers to accessing the PCMP and, if appropriate, to assist the Member in changing the attributed PCMP.

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

5.4.11 The Department has provided an estimate of the number of Members that would be enrolled in each RAE, based on PCMP panel size and region location as of October 1, 2016. Additional enrollment estimate information can be found in Appendix G RAE Map and Enrollment Estimate.

RAE	Number Of Current PCMPs in Each Region (based on county where provider is located)	Projected Enrollment (using expanded ACC eligibility criteria)
1	140	198,140
2	43	92,378
3	105	314,711
4	90	132,828
5	69	210,673
6	85	149,942
7	78	188,235
Total	**610**	**1,286,907**

5.5 MEMBER ENGAGEMENT

5.5.1 Person- and Family-Centered Approach

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

5.5.1.1.1 Responsiveness to Member and family/caregiver needs, including communication and cultural preferences

5.5.1.1.2 Utilization of various tools to communicate clearly and concisely

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

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

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

5.5.1.3 The Contractor shall be aware of the work being done and recommendations made by the Department's Person- and Family-Centeredness Advisory Council, which consists of Medicaid and CHP+ Clients, family members and/or caretakers.

5.5.2 Cultural Responsiveness

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

5.5.2.2 The Contractor shall develop and/or provide cultural competency training programs, as needed, to Network Providers and Contractor staff regarding:

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

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

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

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

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

5.5.2.5 Language Assistance Services

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

5.5.2.5.2 The Contractor shall make oral interpretation available in all languages and written translation available in each prevalent non-English language.

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

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

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

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

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

5.5.2.5.3.2 Written translation in prevalent languages.

5.5.2.5.3.3 Auxiliary aids and services for Members with disabilities.

5.5.2.5.4 Language assistance services shall include the use of auxiliary aids such as TTY/TDY and American Sign Language.

5.5.2.5.5 Customer service telephone functions must easily access interpreter or bilingual services.

5.5.2.6 Written Materials for Members

5.5.2.6.1 The Contractor shall ensure that all written materials it creates for distribution to any Member meets all noticing requirements of 42 C.F.R. § 92.

5.5.2.6.2 The Contractor shall ensure that all written materials it creates for distribution to any Member shall be culturally and linguistically appropriate to the recipient.

5.5.2.6.3 The Contractor shall write all materials in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 C.F.R § 438 and 42 C.F.R. § 92.

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

5.5.2.6.4.1 The Contractor shall post Taglines in at least the top fifteen (15) languages spoken by individuals with limited English proficiency in Colorado in significant publications and significant communications targeted to Members and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures.

5.5.2.6.4.2 The Contractor shall post Taglines in at least the top two (2) languages spoken by individuals with limited English proficiency in the Contractor's region, in a conspicuously visible font size, in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures.

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

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

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

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

5.5.2.6.7 The Contractor shall ensure that its written materials for Members are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members with disabilities, Members who are visually impaired and Members who have limited reading proficiency.

5.5.2.6.8 The Contractor shall ensure that its written materials for Members include a large print (no smaller than 18 point font size) Tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll-free and TTY/TDY telephone number of the Contractor's Member service unit.

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

5.5.3 Member Communication

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

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

5.5.3.3 General Member Information Requirements

5.5.3.3.1 The Contractor shall collaborate with the Department in developing electronic and written materials for distribution to newly enrolled and existing Members in accordance with 42 C.F.R. § 438.10 that must include, at a minimum, all of the following:

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

5.5.3.3.1.2 Contractor's Email address.

5.5.3.3.1.3 Contractor's website address.

5.5.3.3.1.4 State relay information.

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

5.5.3.3.1.6 Which populations are subject to mandatory enrollment into the Program.

5.5.3.3.1.7 The service area covered by the Contractor.

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

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

5.5.3.3.1.10 A directory of Network Providers.

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

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

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

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

5.5.3.4 Notice of Privacy Practices

5.5.3.4.1 Upon initial enrollment, and annually thereafter, the Contractor shall distribute to each Member a copy of the notice of privacy practices. The notice shall comply with 45 C.F.R. § 164.520.

5.5.3.5 Member Rights

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

5.5.3.5.2 The Contractor shall provide information to Members regarding their Member Rights as stated in 42 C.F.R. § 438.100 that includes, but is not limited to:

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

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

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

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

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

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

5.5.3.5.2.7 Freely exercise his or her rights with the Contractor or its providers treating the Member adversely.

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

5.5.3.5.3.1 Members.

5.5.3.5.3.2 Member's families.

5.5.3.5.3.3 Providers.

5.5.3.5.3.4 Case workers.

5.5.3.5.3.5 Stakeholders.

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

5.5.3.6 Member Handbook

5.5.3.6.1 The Contractor shall collaborate with the Department to create a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 C.F.R. § 438.100 and must include, at a minimum, all of the following:

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

5.5.3.6.1.2 The amount, duration, and scope of benefits available under the contracts in sufficient detail to ensure that Member understands the benefits to which they are entitled.

5.5.3.6.1.3 Procedures for obtaining benefits, including authorization requirements.

5.5.3.6.1.4 Extent to which, and how, Member's may obtain benefits from out-of-network providers.

5.5.3.6.1.5 Extent to which, and how, after hours and emergency coverage are provided. This information must include at least the following:

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

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

5.5.3.6.1.5.3 An explanation that post-stabilization care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition when the Contractor does not respond to a request for pre-approval within one (1) hour, the Contractor cannot be contacted, or the Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a Managed Care Entity physician is not available for consultation.

5.5.3.6.1.5.4 The fact that prior authorization is not required for emergency services.

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

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

5.5.3.6.1.5.7 The fact that the Member has the right to use any hospital or other setting for emergency care.

5.5.3.6.1.6 How and where to access any benefits that are available under the State Plan but not covered under the Contract, including cost sharing and how transportation is provided.

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

5.5.3.7 Contractor Website

5.5.3.7.1 The Contractor shall develop and maintain a customized and comprehensive website that follows modern principles of optimizing user experience on mobile and personal computer platforms and is navigable by low literacy, low income, racially diverse populations. The Contractor's website shall provide online access to general customer service information that includes, but is not limited to:

5.5.3.7.1.1 Contractor's contact information.

5.5.3.7.1.2 Member rights and handbooks.

5.5.3.7.1.3 Grievance and Appeal procedures and rights.

5.5.3.7.1.4 General functions of the Contractor.

5.5.3.7.1.5 Trainings.

5.5.3.7.1.6 Provider directories and contact information, including the names, locations, telephone numbers, and non-English languages spoken by current contracted providers, as well as identification of providers that are not accepting new Medicaid Members.

5.5.3.7.1.7 Access to care standards.

5.5.3.7.1.8 Health First Colorado Nurse Advice Line.

5.5.3.7.2 The Contractor shall link to the Department's website for standardized information such as Member rights and handbooks.

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

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

5.5.3.8 Termination of Provider Agreement

5.5.3.8.1 Upon termination of a Network Provider's agreement or participation with the Contractor, for any reason, the Contractor shall notify any Member, who has selected that Network Provider, of that Network Provider's termination, as required in 42 C.F.R. § 438.10(f)(1).

5.5.3.9 Information on Grievance and Appeals Process

5.5.3.9.1 The Contractor shall provide information to Members on Grievance, Appeals and State Fair Hearing procedures and timelines (as relevant and described in Section 5.6). The description shall include at least the following:

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

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

5.5.3.9.1.3 Requirements and timeframes for filing a Grievance or Appeal.

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

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

5.5.3.9.1.6 The method for obtaining a State Fair Hearing.

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

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

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

5.5.3.10 Advance Directives

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

5.5.3.10.1.1 A description of applicable state law.

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

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

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

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

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

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

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

5.5.3.11 Other information

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

5.5.3.12 Member Material Review Process

5.5.3.12.1 The Contractor shall submit all Member materials to the Department at least ten (10) Business Days prior to the Contractor printing or disseminating such materials to any Member, unless the Department approves a shorter submission deadline.

5.5.3.12.2 The Contractor shall ensure that all Member materials have been Member-tested prior to submission to the Department.

5.5.3.12.3 For each Member material submitted for Department review, the Contractor shall document the audience, purpose, delivery method, and frequency.

5.5.3.12.4 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 and that the document aligns with the Department priorities and standards. The Contractor shall make any required changes to the materials.

5.5.3.12.5 This submission requirement shall not apply to individualized correspondence that is directed toward a specific Member.

5.5.3.13 Electronic Distribution of Federally Required Information

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

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

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

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

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

5.5.3.13.1.5 The Member is informed that the information is available in paper form without charge upon request and the Contractor provides the information upon request within five (5) Business Days.

5.5.4 Marketing

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

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

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

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

5.5.4.5 The Contractor shall distribute the materials to the entire Region as defined by the Contract.

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

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

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

5.5.4.9 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.

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

5.5.5 Health Needs Survey

5.5.5.1 The Department has developed a Health Needs Survey to be completed by Clients during enrollment to capture some basic information about a Member's individual needs. The Health Needs Survey is a brief set of questions capturing important and time-sensitive health information (Appendix H Health Needs Survey) that shall be used by the Contractor to inform Member outreach and Care Coordination activities.

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

5.5.5.2.1 The Contractor shall review the Member responses to the Health Needs Survey on a regular basis to identify Members who may benefit from timely contact and support from the Member's PCMP and/or RAE.

5.5.6 Member Education of Medicaid Benefits

5.5.6.1 The Contractor shall actively participate in Department activities for Member onboarding and engagement.

5.5.6.2 The Contractor shall collaborate with Healthy Communities contractors in the Contractor's Region for onboarding Members to Medicaid and the Program. Healthy Communities will have contracted responsibilities to onboard Members to Medicaid and the Program through outreach, navigation support of Medicaid benefits, and education on preventive services, particularly services for children and families.

5.5.6.2.1 The Contractor shall establish Memorandums of Understanding (MOUs) with all Healthy Communities contractors in the Contractor's Region to support alignment of onboarding activities and sharing of Member information.

5.5.6.2.2 The Contractor shall be able to accept regular data transfers generated by the Salesforce data platform used by Healthy Communities to facilitate Care Coordination and other Member interventions.

5.5.6.2.3 The Contractor shall partner with Healthy Communities contractors to create an annual Collaboration Plan that includes, but is not limited to, the following information:

5.5.6.2.3.1 Designation of roles and responsibilities for Member outreach, navigation, and education activities.

5.5.6.2.3.2 Activities to maximize outreach to Members.

5.5.6.2.3.3 Processes to prevent duplication of onboarding activities.

5.5.6.2.4 The Contractor shall train Healthy Communities contractors about the Program and the Contractor's unique interventions and processes.

5.5.6.2.5 The Contractor shall refer Members and their families to Healthy Communities for assistance with EPSDT, finding Community resources and navigating child and family services.

5.5.7 Promotion of Member Health and Wellness

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

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

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

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

5.5.8 Member Engagement Report

5.5.8.1 The Contractor shall submit a report to the Department every six (6) months describing how the Contractor engaged Members and Community stakeholders in the Accountable Care Collaborative in a format determined by the Department.

5.5.9 Deliverables

5.5.9.1 DELIVERABLE: Member Engagement Report

5.5.9.1.1 DUE: Every six (6) months.

5.5.9.2 DELIVERABLES: Colorado Medicaid Member Handbook section specific to the Contractor's Region.

5.5.9.2.1 DUE: Thirty (30) days from the Contract's Effective Date.

5.5.9.3 DELIVERABLES: Updated Member Handbook section specific to the Contractor's Region whenever significant changes occur.

5.5.9.3.1 DUE: Thirty (30) days from when changes take effect.

5.5.9.4 DELIVERABLE: Network Directory

5.5.9.4.1 DUE: Five (5) days prior to the Operational Start Date and monthly by the first day of the month, unless an extension is allowed by the Department.

5.5.9.5 DELIVERABLE: Updated Member materials including changes required by the Department.

5.5.9.5.1 DUE: Thirty (30) days from the request by the Department to make a change

5.5.9.6 DELIVERABLE: Notice to Members of PCMP termination.

5.5.9.6.1 DUE: Fifteen (15) days from the notice of termination.

5.6 GRIEVANCES AND APPEALS

5.6.1 In accordance with 42 C.F.R. § 438.400, the Contractor shall have a Grievance and Appeal system to handle Grievances about any matter related to this Contract other than an adverse benefit determination and Appeals of an adverse benefit determination for the Capitated Behavioral Health Benefit, as well as processes to collect and track information about them.

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

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

5.6.4 The Contractor shall inform Network Providers and subcontractors about:

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

5.6.4.1.1 The requirements and timeframes for filing.

5.6.4.1.2 The availability of assistance with filing.

5.6.4.1.3 The toll-free number to file orally.

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

5.6.4.3 The Member's right to request a continuation of benefits during an Appeal or State Fair Hearing filing, although the Member may be liable for the cost of any continued benefits if the adverse benefit determination is upheld.

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

5.6.5 Grievances

5.6.5.1 The Contractor shall establish and maintain a Grievance process through which Members may express dissatisfaction about any matter related to this Contract other than an adverse benefit determination.

5.6.5.2 The Contractor shall ensure that information about the Grievance process, including how to file a Grievance, is available to all Members and is given to all providers and subcontractors.

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

5.6.5.4 The Contractor shall ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were a subordinate of anyone who was. The decision maker shall be a health care professional with clinical expertise in treating the Member's condition or disease for any Grievance involving clinical issues.

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

5.6.5.6 If a Member is dissatisfied with the disposition of a Grievance, the Member may bring the unresolved Grievance to the Department. The Department's decision is final.

5.6.5.7 The Contractor shall document problems a Network Provider submits to the Contractor, and the solutions the Contractor has offered to the provider. The Department may review any of the documented solutions. If the Department determines the solution to be insufficient or otherwise unacceptable, it may direct the Contractor to find a different solution or follow a specific course of action.

5.6.5.7.1 If the Department is contacted by a Member, family members or caregivers of a Member, advocates, the Ombudsman for Medicaid Managed Care, and other individuals/entities with a Grievance regarding concerns about the care or lack of care a Member is receiving, the Contractor shall address all issues as soon as possible after the Department has informed the Contractor of the concerns. The Contractor shall keep the Department informed about progress on resolving concerns in real time, and shall advise the Department of final resolution.

5.6.6 Notice of Adverse Benefit Determination

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

5.6.6.1.1 Is in writing.

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

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

5.6.6.1.4 Is in an easily understood language and format.

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

5.6.6.1.6 Explains the reasons for the adverse benefit determination.

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

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

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

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

5.6.6.1.11 Explains the Member's right to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of continued services.

5.6.6.2 The Contractor shall give notice according to the following schedule:

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

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

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

5.6.6.2.3.1 The recipient has died.

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

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

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

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

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

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

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

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

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

5.6.6.2.5 As expeditiously as the Member's health condition requires, within ten (10) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

5.6.6.2.5.1 The Contractor may extend the ten (10) calendar day service authorization notice timeframe of up to fourteen (14) additional days if the Member or the Provider requests extension; or if the Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

5.6.6.2.5.2 If the Contractor extends the ten (10) day service authorization notice timeframe, it must give the Member written notice of the reason for the extension and inform the Member of the right to file a Grievance if he/she disagrees with the decision.

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

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

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

5.6.7 Handling Appeals for the Capitated Behavioral Health Benefit

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

5.6.7.2 The Contractor shall ensure that decision makers on Appeals were not involved in previous levels of review or decision-making.

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

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

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

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

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

5.6.7.4.2 Either orally or in writing, and unless an expedited resolution is requested, follow the oral filing with a written, signed, Appeal.

5.6.7.5 The Contractor shall ensure that oral inquiries seeking to Appeal an adverse benefit determination are treated as Appeals, and confirmed in writing unless the Member or the Provider requests expedited resolution.

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

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

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

5.6.7.9 The Contractor shall give the Member and the Member's representative an opportunity, before and during the Appeals process, to examine the Member's case file, including medical records and any other documents and records.

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

5.6.7.11 Continuation of Benefits and Services During an Appeal

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

5.6.7.11.1.1 The Appeal is filed on or before the later of

5.6.7.11.1.1.1 Within ten (10) days of the Contractor mailing the notice of adverse benefit determination.

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

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

5.6.7.11.1.3 The services were ordered by an authorized Provider.

5.6.7.11.1.4 The authorization period has not expired.

5.6.7.11.1.5 The Member requests an extension of benefits.

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

5.6.7.11.2.1 The Member withdraws the Appeal.

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

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

5.6.7.11.2.4 The service authorization expires or the authorization limits are met.

5.6.7.11.3 The Contractor may recover the cost of the continued services furnished to the Member while the Appeal was pending if the final resolution of the Appeal upholds the Contractor's adverse benefit determination.

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

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

5.6.7.11.6 The Contractor shall notify the requesting Provider and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

5.6.7.12 Resolution and Notification of Appeals

5.6.7.12.1 The Contractor shall resolve each Appeal and provide notice as expeditiously as the Member's health condition requests, and not to exceed the following:

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

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

5.6.7.12.2.1 The Contractor shall provide the Member with written notice within two (2) calendar days of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member.

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

5.6.7.12.3.1 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the standard timeframe for Appeal resolution and give the Member prompt oral notice of the denial and a written notice within two (2) calendar days of receiving the request for expedited resolution.

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

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

5.6.7.12.3.4 The Contractor shall provide the Member with written notice within two (2) calendar days of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member.

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

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

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

5.6.7.12.5.1 Right to request a State Fair Hearing.

5.6.7.12.5.2 How to request a State Fair Hearing.

5.6.7.12.5.3 The right to continue to receive benefits pending a hearing.

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

5.6.7.13 State Fair Hearing

5.6.7.13.1 The Contractor shall allow a Member to request a State Fair Hearing. The Member must exhaust the Contractor Appeal process before requesting a State Fair Hearing. The Member has one hundred and twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Fair Hearing.

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

5.6.7.13.3 The parties to the State Fair Hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

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

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

5.6.7.14 Expedited State Fair Hearing

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

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

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

5.6.8 Ombudsman for Medicaid Managed Care

5.6.8.1 The Contractor shall utilize and refer Members to the Ombudsman for Medicaid Managed Care to assist with problem-solving, Grievance resolution, in-plan and administrative law judge hearing level Appeals, and referrals to Community resources, as appropriate.

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

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

5.6.9 Grievance and Appeals Report

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

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

5.6.9.1.2 The date received.

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

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

5.6.9.1.5 Date of resolution at each level, if applicable.

5.6.9.1.6 Name of the covered person for whom the Appeal or Grievance was filed.

5.6.9.2 DELIVERABLE: Grievance and Appeal Report

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

5.7 NETWORK DEVELOPMENT AND ACCESS STANDARDS

5.7.1 Establishing a Network

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

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

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

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

5.7.1.3.1 Public and Private providers, including independent practitioners.

5.7.1.3.2 Federally Qualified Health Centers (FQHC).

5.7.1.3.3 Rural Health Clinics (RHC).

5.7.1.3.4 Community Mental Health Centers (CMHC).

5.7.1.3.5 School Based Health Centers (SBHC).

5.7.1.3.6 Providers capable of billing both Medicare and Medicaid.

5.7.1.3.7 Essential Community Providers (ECP).

5.7.1.3.8 Indian Health Care Providers.

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

5.7.1.4.1 The anticipated number of Members.

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

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

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

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

5.7.1.5 The Contractor shall develop and implement a strategy to recruit and retain qualified, diverse and culturally responsive Providers including, but not limited to, providers who represent racial and ethnic communities, the deaf and hard of hearing community, the disability community and other culturally diverse communities who may be served. The Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds.

5.7.1.6 The Contractor shall implement written policies and procedures for the selection and retention of providers.

5.7.1.6.1 The Contractor's provider selection policies and procedures, consistent with 42 C.F.R. § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

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

5.7.1.8 The Contractor's networks shall provide the Contractor's Members with a reasonable choice of providers.

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

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

5.7.1.11 The Contractor shall notify the Department of an unexpected or expected network change that could adversely affect network service delivery or create a network deficiency.

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

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

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

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

5.7.2 PCMP Network

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

5.7.2.1.1 Enrolled as a Colorado Medicaid provider.

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

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

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

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

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

5.7.2.1.5.1 Physician (Code 05).

5.7.2.1.5.2 Osteopath (Code 26).

5.7.2.1.5.3 Federally Qualified Health Center (Code 32).

5.7.2.1.5.4 Rural Health Clinic (Code 45).

5.7.2.1.5.5 School Health Clinic (Code 51).

5.7.2.1.5.6 Family/Pediatric Nurse Practitioner (Code 41).

5.7.2.1.5.7 Clinic-Practitioner Group (Code 16).

5.7.2.1.5.8 Non-physician Practitioner Group (Code 25).

5.7.2.1.6 Provides Care Coordination.

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

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

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

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

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

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

5.7.2.1.13 Uses an electronic health record or are working with the Contractor to share data with the Department.

5.7.2.2 The Contractor may waive, in limited circumstances, some of the PCMP criteria in order to achieve network access and adequacy standards (as defined in Section 5.7.7). The reasons for waiving these requirements must be documented in the Contractor's Network Report deliverable. The Contractor shall partner with these PCMPs to identify practice goals and support them in working toward achieving these goals.

5.7.2.3 The Contractor shall contract with all PCMP Practice Sites located within the Contractor's region.

5.7.2.3.1 Each Practice Site within a health organization, group, or system is counted as a separate PCMP Practice Site for the purposes of the Contactor's PCMP network.

5.7.3 Specialty Behavioral Health Provider Network

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

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

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

5.7.3.4 Behavioral Health Provider Credentialing and Re-credentialing

5.7.3.4.1 The Contractor shall ensure that all Network Providers are credentialed.

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

5.7.3.4.1.2 Accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) may satisfy individual credentialing elements required by this Contract or NCQA credentialing standards, if the Department deems the elements to be substantially equivalent to the NCQA elements and/or standards.

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

5.7.3.5 The Contractor shall assure that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

5.7.4 Access to Care Standards

5.7.4.1 The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to:

5.7.4.1.1 Serve all primary care and care coordination needs;

5.7.4.1.2 Serve all behavioral health needs; and

5.7.4.1.3 Allow for adequate Member freedom of choice amongst providers.

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

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

5.7.4.4 The Contractor's network shall provide for extended hours (outside of the hours from 8:00 a.m.–5:00 p.m.) on evenings and weekends and alternatives for emergency room visits for after-hours urgent care.

5.7.4.4.1 Evening and weekend support services for Members and families shall include access to clinical staff, not just an answering service or referral service staff.

5.7.4.5 The Contractor shall implement a network management process and maintain an up-to-date database or directory of contracted providers approved to deliver services, which includes all the information listed in Section 5.5.3.4. of this contract. The directory shall be updated at least monthly and shall be made available to the Department.

5.7.4.6 The Contractor's network shall provide for twenty-four (24) hour a day availability of information, referral and treatment of emergency medical conditions in compliance with 42 C.F.R. § 438.3(q)(1).

5.7.4.7 The Contractor's PCMP network shall comply with the access standards set by the Department in its Access Monitoring Review Plan.

5.7.4.7.1 Until the Department finalizes the Access Monitoring Review Plan, the Contractor shall comply with the PCMP network time and distance standards in the following table.

PCMP Network Time and Distance Standards

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Adult Primary Care Providers	30	30	45	45	60	60
Pediatric Primary Care Providers	30	30	45	45	60	60
Gynecology, OB/GYN	30	30	45	45	60	60

5.7.4.8 The Contractor's PCMP network shall have a sufficient number of PCMPs so that 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.

5.7.4.8.1 In the event that there are less than two (2) practitioners that meet the PCMP standards within the defined area for a specific Member, then the requirements of the prior paragraph shall not apply to that Member.

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

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

Behavioral Health Network Time and Distance Standards

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Hospitals (acute care)	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers, for adults	30	30	60	60	90	90
Psychiatrists and other psychiatric prescribers; serving children	30	30	60	60	90	90
Mental Health Provider; serving adults	30	30	60	60	90	90

Mental Health Provider; serving children	30	30	60	60	90	90
Substance Use Disorder Provider; serving adults	30	30	60	60	90	90
Substance Use Disorder Provider; serving children	30	30	60	60	90	90

5.7.4.10 The Contractor's behavioral health network shall have a sufficient number of providers so that each Member has their choice of at least two (2) behavioral health providers 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.

5.7.4.10.1.1 In the event that there are no behavioral health providers who meet the behavioral health provider standards within the defined area for a specific Member, then the time and distance requirements of the prior table shall not apply to that Member.

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

5.7.4.11 The Contractor shall ensure that its network meets the following practitioner to Client ratios and distance standards:

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

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

5.7.4.11.3 Pediatric primary care providers: One (1) PCMP Provider per twenty-five five hundred (2,500) child Members.

5.7.4.11.4 Mental Health Providers: One (1) practitioner per fifteen hundred (1,500) Members.

5.7.4.11.5 Substance Use Disorder Providers: One (1) practitioner per fifteen hundred (1,500) Members.

5.7.4.12 The Contractor shall maintain sufficient Indian or Tribal providers in the network to ensure timely access to services available under the contract for Indian Members who are eligible to receive services from such providers, in accordance with the American Recovery and Reinvestment Act of 2009.

5.7.4.13 The Contractor shall ensure its network is sufficient so that services are provided to Members on a timely basis, as follows:

5.7.4.13.1 Urgent Care – within twenty-four (24) hours of the initial identification of need;

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

5.7.4.13.3 Non-urgent, Symptomatic Care Visit – within seven (7) days of the request;

5.7.4.13.4 Well Care Visit – within one (1) month of the request; unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Early Periodic Screening, Diagnostic and Treatment (EPSDT) schedules.

5.7.4.13.5 The additional timeliness standards apply only to the Capitated Behavioral Health Benefit:

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

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

5.7.4.13.5.2.1 Administrative intake appointments or group intake processes are not considered a treatment appointment for non-urgent, symptomatic care.

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

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

5.7.4.14.1 Utilizing out-of-network providers

5.7.4.14.2 Using financial incentives to induce network or out-of-network providers to accept Members

5.7.4.15 The Contractor shall have a system in place for monitoring patient load in their provider network and recruit providers as necessary to assure adequate access to all covered services.

5.7.4.16 Network Changes and Deficiencies

5.7.4.16.1 The Contractor shall notify the Department, in writing, within five (5) Business Days of Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network. The notice shall include:

5.7.4.16.1.1 Information describing how the change will affect service delivery.

5.7.4.16.1.2 Availability, or capacity of covered services.

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

5.7.4.16.1.4 A plan to correct any network deficiency.

5.7.5 Network Adequacy Plan and Report

5.7.5.1 The Contractor shall submit a single Network Adequacy Plan to the Department annually that contains, at a minimum, the following information for both its PCMP and behavioral health Network.

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

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

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

5.7.5.1.3.1 Adult primary care providers.

5.7.5.1.3.2 Pediatric primary care providers.

5.7.5.1.3.3 OB/GYN.

5.7.5.1.3.4 Adult mental health providers.

5.7.5.1.3.5 Pediatric mental health providers.

5.7.5.1.3.6 Substance use disorder providers.

5.7.5.1.3.7 Psychiatrists.

5.7.5.1.3.8 Child psychiatrists.

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

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

5.7.5.1.6 Cultural and language expertise of providers.

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

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

5.7.5.1.9 Case load for behavioral health providers.

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

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

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

5.7.5.2.1 Percent of PCMPs accepting new Medicaid Members.

5.7.5.2.2 Percent of behavioral health providers accepting new Medicaid Members.

5.7.5.2.3 Percent of PCMPs offering after-hours appointment availability to Medicaid Members.

5.7.5.2.4 Percent of behavioral health providers offering after-hours appointments.

5.7.5.2.5 Performance meeting timeliness standards.

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

5.7.5.2.7 Providers recruited that quarter.

5.7.5.2.8 Providers that left the Contractor's network.

5.7.5.2.9 Additional information, as requested by the Department.

5.7.6 Deliverables

5.7.6.1 DELIVERABLE: Network Adequacy Plan

5.7.6.1.1 DUE: Annually, on July 31.

5.7.6.2 DELIVERABLE: Network Report

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

5.7.6.3 DELIVERABLE: Provider Credentialing Policies and Procedures.

5.7.6.3.1 DUE: Within sixty (60) days following the Operational Start Date.

5.7.6.4 DELIVERABLE: Network Changes and Deficiencies.

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

5.8 HEALTH NEIGHBORHOOD AND COMMUNITY

5.8.1 The Contractor shall promote Members' physical and behavioral well-being by creating a Health Neighborhood and Community consisting of a diverse network of health care providers and Community organizations.

5.8.2 The Contractor's efforts shall include increasing Member access to timely and appropriate Medicaid services and benefits, and the promotion of healthy Communities that can positively impact the conditions in which Members live.

5.8.3 Health Neighborhood

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

5.8.3.2 The Contractor shall establish and strengthen relationships among its Network Providers and the Health Neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes.

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

5.8.3.4 The Contractor shall identify barriers to provider participation in the Health Neighborhood, such as ineffective referral processes, high no-show rates of Members, and ineffective communication, and work to design and implement approaches to address these barriers to enable providers to appropriately care for more Medicaid Members. The Contractor may share claims data as appropriate, provide Care Coordination support, establish financial relationships, or other approaches to support the efficient use of specialty care resources.

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

5.8.3.5.1 The Contractor shall promote and ensure the systematic utilization of the Colorado Medical Society's Primary Care-Specialty Care Compact (Appendix S CMS Care Compact) among providers in the region's Health Neighborhood. The compact is an agreement that can be implemented between any Medicaid provider to foster proactive communication, collaborative care management and planning across diverse care settings.

5.8.3.5.2 The Contractor shall promote and ensure the use of the Department-adopted electronic consultation software, through which specialists consult with PCMPs via a telecommunication platform. Electronic consultations allows specialists to receive reimbursement for timely review of clinical information and providing Member specific recommendations on how a PCMP may manage a condition and whether a specialty visit is required. Electronic consultations have been shown to increase appropriate access to specialty care, improve both physician satisfaction and Member experience, and improve overall quality of care.

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

5.8.3.6 The Contractor shall acknowledge that hospitals are an essential part of the health care delivery system and Health Neighborhood and shall collaborate with hospitals to improve care transitions and address complex Member needs.

5.8.3.7 The Contractor shall utilize admit/discharge/transfer data to track emergency room utilization and improve the quality of care transitions into and out of hospitals. The Contractor shall coordinate with hospitals directly or use a Health Information Exchange to access hospital admit/discharge/transfer Data.

5.8.3.8 The Contractor shall collaborate with hospitals to implement the DSRIP Program, a Section 1115 waiver program that, if granted, will give Colorado Medicaid the opportunity to tie hospital payments to performance. DSRIP gives the Department another tool to connect hospitals to the Health Neighborhood and align hospital incentives with the goals of the Accountable Care Collaborative Program.

5.8.3.8.1 The Contractor shall work with the Department to understand how DSRIP will work in Colorado, and the hospitals' role and responsibilities.

5.8.3.8.2 The Contractor shall help hospitals determine priorities and select projects, interventions and performance goals for DSRIP.

5.8.3.9 The Contractor shall collaborate with LTSS providers and care coordinators/case managers to develop a holistic approach to assisting LTSS Members achieve their health and wellness goals.

5.8.3.9.1 The Contractor shall work to improve coordination of long-term services and supports with Members' physical and behavioral health needs through a variety of methods, such as developing policies and/or means of sharing Member information.

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

5.8.3.11 The Contractor shall establish relationships and communication channels with the Non-Emergency Medical Transportation vendor in order to ensure Members are able to attend their medical appointments on time. Members' health is often negatively impacted when they miss appointments, particularly with specialty care providers, and can result in over utilization of the emergency department. Strengthening the relationship of the Non-Emergency Medical Transportation vendor with members of the Health Neighborhood and implementing initiatives to increase efficiency can significantly improve provider satisfaction, Member experience, and Member health.

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

5.8.3.13 The Contractor shall collaborate with local public health agencies to:

5.8.3.13.1 Design opportunities for integration of local public health activities into the Program.

5.8.3.13.2 Identify any specific target activities to meet the health needs of Members in the region, such as enrollment, health promotion, population health initiatives, and dissemination of public health information.

5.8.3.13.3 Explore appropriate funding approaches to support collaborative activities.

5.8.4 Community and the Social Determinants of Health

5.8.4.1 The Contractor shall demonstrate an understanding of the health disparities and inequities in their region and develop plans with providers, Members and Community stakeholders to optimize the physical and behavioral health of its Members.

5.8.4.2 Recognizing that the conditions in which Members live also impact their health and well-being, the Contractor shall establish relationships and collaborate with economic, social, educational, justice, recreational and other relevant organizations to promote the health of local communities and populations.

5.8.4.3 The Contractor shall be responsible for knowing, understanding and implementing initiatives to build local communities to optimize Member health and well-being, particularly for those Members with complex needs that receive services from a variety of agencies.

5.8.4.4 The Contractor shall establish relationships and communication channels with Community organizations that provide resources such as food, housing, energy assistance, childcare, education and job training in the region.

5.8.4.5 The Contractor shall have and maintain a centralized regional resource directory listing all Community resources available to Members and share the information with providers and Members.

5.8.4.5.1 The Contractor shall not duplicate Community efforts to create a directory. Instead, the Contractor shall leverage and/or participate in any existing state or regional efforts to build a regional resource directory.

5.8.4.6 The Contractor shall identify and promote Member engagement with evidence-based and promising initiatives operating in the region that address the social determinants of health. The Contractor shall align with the framework set up through the Colorado Opportunity Project, a state multi-agency initiative (see https://www.colorado.gov/pacific/hcpf/colorado-opportunity-project for more information).

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

5.8.4.8 The Contractor shall share information with Community organizations in the region about identified Community social service gaps and needs.

5.8.4.9 As hospitals serve as an anchor for many Communities, the Contractor shall engage with hospitals to perform community health needs assessments and to develop and implement strategies to reduce health inequities and disparities in the Community.

5.8.4.10 The Contractor shall collaborate with the Department and other state agencies in order to expand the Community resources available to Members.

5.8.5 Statewide Health Infrastructure

5.8.5.1 The Contractor shall participate in and align its activities with advisory groups, existing programs and statewide initiatives designed to strengthen the health care system, including:

5.8.5.1.1 State Innovation Model (SIM): focused on the integration of physical and behavioral health services.

5.8.5.1.2 Comprehensive Primary Care Initiative (CPC+): a CMS led, multi-payer effort fostering collaboration between public and private health care payers to strengthen primary care.

5.8.5.1.3 Community Living Advisory Group: recommended LTSS system changes to enhance community living options and provided direction to Office of Community Living as changes are implemented.

5.8.5.1.4 Benefits Collaborative: the Department's formal process to establish the amount, scope, and duration of fee-for-service benefits, ensure that covered services are evidence-based and guided by best practices, and develop working relationships and collaborate with stakeholders.

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

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

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

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

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

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

5.8.5.1.6.4 The Contractor shall work with the UM vendor regarding Members identified for the Department's COUP program as described in Section 5.14.6.2.

5.8.6 Health Neighborhood and Community Report

5.8.6.1 The Contractor shall submit a report to the Department every six (6) months describing the Contractor's recent activities to engage and build the Health Neighborhood and Community, including the following information:

5.8.6.1.1 Participation in Community efforts

5.8.6.1.2 Creation of new Health Neighborhood and Community forums

5.8.6.1.3 Collaboration with hospitals

5.8.6.1.4 Efforts to utilize Admit/Discharge/Transfer data to improve transitions of care and results of those efforts

5.8.6.1.5 Activities to engage LTSS providers

5.8.6.1.6 Activities to increase regional provider enrollment in Medicaid

5.8.6.1.7 Activities to increase regional provider Medicaid Member panels

5.8.6.1.8 Recruitment efforts and training for utilization of electronic consultation

5.8.6.1.9 Collaboration with hospitals on DSRIP

5.8.6.1.10 Collaboration with Local Public Health Agencies

5.8.6.1.11 Activities to engage Members with evidence-based/promising practice programs in the Community

5.8.6.1.12 Identification of barriers to access of Health Neighborhood and Community resources and proposed initiatives to address the barriers

5.8.6.1.13 Progress on reducing roadblocks to Health Neighborhood and Community resources

5.8.7 Deliverables

5.8.7.1 DELIVERABLE: Health Neighborhood and Community Report

5.8.7.1.1 DUE: Every 6 months, by January 31 and July 31 of each year.

5.9 POPULATION HEALTH MANAGEMENT AND CARE COORDINATION

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

5.9.1.1 The Contractor shall use a health promotion/population health management approach to assess, track and manage the health needs and outcomes of all its Members in order to improve health, control costs and improve the experience of care.

5.9.1.2 The Contractor shall recognize that population health management requires a detailed understanding of the distribution of health conditions and health related behaviors, and is strengthened by the consideration of social determinants of health, such as income, culture, race, age, family status, housing status, and education level. The Contractor shall possess capabilities to leverage and build upon the Department's data systems and perform analytics to successfully implement an information-based approach to delivering and coordinating care and services across the continuum.

5.9.1.3 The Contractor shall have a comprehensive approach to population health management that uses data to stratify the population and offers a range of interventions to support Members at all life stages and levels of health; Care Coordination must be one of the interventions available to Members.

5.9.2 Population Health Management

5.9.2.1 The Contractor shall develop and submit to the Department an overall strategy for population health management segmented by pediatric and adult populations using the template in Appendix I Population Health Management Plan.

5.9.2.2 The Contractor's Population Health Management Plan shall include, at a minimum, the following information:

5.9.2.2.1 The Contractor's methodology to stratify the population it serves based on health status or other factors, including social determinants of health and health equity, as information is available.

5.9.2.2.2 Description of how often the Contractor plans to run the Stratification Methodology to stratify Members, what would prompt re-stratification for the entire population, and how the Contractor will identify Members who change stratification level, particularly into higher risk categories.

5.9.2.2.3 Crosswalk of stratification levels and the interventions the Contractor plans to have available for each level

5.9.2.2.4 Descriptions of each intervention the Contractor will offer, including, at a minimum, the following information:

5.9.2.2.4.1 Whether the intervention is an evidence-based practice, promising local initiative, or other type of activity.

5.9.2.2.4.2 How the Contractor will determine the frequency in which the intervention will be offered.

5.9.2.2.4.3 How the Contractor will determine who will deliver the intervention, including Care Coordination.

5.9.2.2.4.4 Potential outcomes likely to result from the intervention and how the Contractor will measure the effectiveness of the intervention.

5.9.2.3 The Contractor shall take into consideration evidence-based practices, promising local initiatives and the Colorado Opportunity Project's endorsed interventions (see https://www.colorado.gov/pacific/hcpf/colorado-opportunity-project) when developing the Population Health Management Plan.

5.9.2.4 The Contractor shall engage Members and Network Providers in developing and revising its Population Health Management Plan, share the final plan with Network Providers, and assist them in delivering Care Coordination, wellness activities and other population health interventions based on the Population Health Management Plan.

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

5.9.2.6 The Contractor shall review the Population Health Management Plan at least annually and submit a revised Plan to the Department when there are changes to the Contractor's strategy.

5.9.2.7 The Contractor shall implement the Population Health Management Plan by performing the following:

5.9.2.7.1 Run the stratification methodology on intervals specified by the Contractor

5.9.2.7.2 Ensure Members are receiving interventions as described

5.9.2.7.3 Report to the Department quarterly using the Stratification Report included in Appendix J

5.9.3 Care Coordination

5.9.3.1 The Contractor shall ensure that Care Coordination is part of the Contractor's Population Health Management Plan.

5.9.3.2 The Contractor shall recognize that Care Coordination incorporates a range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being.

5.9.3.3 The Contractor shall recognize that Care Coordination occurs in many ways from deliberate provider interventions to coordinate with other aspects of the health system, to interventions over an extended period of time by an individual designated to coordinate a Member's health and social needs.

5.9.3.4 The Contractor shall use a person-centered approach to Care Coordination, which takes into consideration the preferences and goals of Members and their families, and then connects them to the resources needed to carry out needed care and follow up.

5.9.3.5 The Contractor shall ensure that care is coordinated within a practice, as well as between the practice and other providers and organizations serving a Member.

5.9.3.6 The Contractor shall not duplicate Care Coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, the Contractor shall work to link and organize the different Care Coordination activities to promote a holistic approach to a Member's care.

5.9.3.7 The Contractor shall ensure that Care Coordination:

5.9.3.7.1 Is accessible to Members

5.9.3.7.2 Is provided at the point of care whenever possible

5.9.3.7.3 Addresses both short and long-term health needs

5.9.3.7.4 Is culturally competent

5.9.3.7.5 Respects Member preferences

5.9.3.7.6 Supports regular communication between care coordinators and the practitioners delivering services to Members

5.9.3.7.7 Reduces duplication and promotes continuity by identifying a lead care coordinator for Members receiving Care Coordination from multiple systems

5.9.3.7.8 Is documented, for both medical and non-medical activities

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

5.9.3.7.10 Aligns with the Contractor's Population Health Management Plan

5.9.3.7.11 Protects Member privacy

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

5.9.3.9 The Contractor shall reasonably ensure that all Care Coordination, including interventions provided by other individuals or entities, meet the needs of the Member.

5.9.3.10 The Contractor shall ensure that Care Coordination is provided to Members who are transitioning between health care settings and populations who are served by multiple systems, including but not limited to children involved with child welfare, Medicaid-eligible individuals transitioning out of the criminal justice system, Members receiving LTSS services, and Members transitioning out of institutional settings. To meet the needs of these Members, the Contractor shall:

5.9.3.10.1 Designate staff persons to serve as the Contractor's single point of contact with the different systems and settings.

5.9.3.10.2 Give designated staff persons the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population.

5.9.3.10.3 Provide specific guidance to care coordinators about each setting, regarding how to identify Members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and Member concerns.

5.9.3.10.4 Participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for populations served by multiple systems.

5.9.3.11 For Members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, the Contractor shall assist the Member in locating appropriate services.

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

5.9.3.13 The Contractor shall intervene when the systems and providers engaged with a Member's complex care require leadership and direction.

5.9.3.14 The Contractor shall ensure that Care Coordination tools, processes, and methods are available to and used by Network Providers (see Section 5.13.2.1.3).

5.9.4 Care Coordination Activity Report

5.9.4.1 The Contractor shall submit a Care Coordination Activity report to the Department every six (6) months in a format agreed to by the Department and the Contractor. The report shall include Care Coordination activities performed by Network Providers and subcontractors. The report shall contain, at a minimum, narrative and statistics that include the following:

5.9.4.1.1 The number of unique Members for whom Care Coordination was provided by the Contractor during the reporting period by the following categories:

5.9.4.1.1.1 Deliberate provider interventions to coordinate with other aspects of the health system.

5.9.4.1.1.2 Care Coordination delivered over an extended period of time.

5.9.4.1.2 Examples of Care Coordination activities performed during the previous quarter.

5.9.4.1.3 Other information identified through a collaborative process.

5.9.5 Deliverables

5.9.5.1 DELIVERABLE: Population Health Management Plan

5.9.5.1.1 DUE: Sixty (60) days after the Contract's Effective Date.

5.9.5.2 DELIVERABLE: Population Health Management Plan Update

5.9.5.2.1 DUE: Upon Contractor's change in strategy.

5.9.5.3 DELIVERABLE: Stratification Report

5.9.5.3.1 DUE: Quarterly, by the 15th business day of the month following the end of the calendar quarter that the report covers.

5.9.5.4 DELIVERABLE: Care Coordination Report

5.9.5.4.1 DUE: Every six (6) months 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; except that the deliverable due November 1, 2018 will be for the reporting period of July 1, 2018 through September 30, 2018.

5.10 PROVIDER SUPPORT AND PRACTICE TRANSFORMATION

5.10.1 The Contractor shall serve as a central point of contact for Network Providers regarding Medicaid services and programs, regional resources, clinical tools, and general administrative information.

5.10.2 The Contractor shall support Network Providers that are interested in integrating primary care and behavioral health services, advancing business practices and use of health technologies, and other activities designed to improve Member health and experience of care.

5.10.3 The Contractor shall offer Network Providers the following types of support, described in further detail in the rest of this section: general information and administrative support, provider training, data systems and technology support, practice transformation, and financial support.

5.10.4 The Contractor shall document its Practice Support Strategy in a Practice Support Plan and update the plan annually. This plan shall specifically describe:

5.10.4.1 The types of information and administrative support, provider trainings, and data and technology support the Contractor will provide.

5.10.4.2 The practice transformation strategies it will use to help practices progress along the Framework for Integration of Whole-Person Care (For more information, see https://www.colorado.gov/healthinnovation/resources-9).

5.10.4.3 The administrative payment strategies the Contractor will use to financially support practices.

5.10.5 General Information and Administrative Support

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

5.10.5.2 The Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for the following topics:

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

5.10.5.2.2 Available Member resources, including the Member provider directory.

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

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

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

5.10.5.3.1 Medicaid eligibility

5.10.5.3.2 Medicaid covered benefits

5.10.5.3.3 State Plan services, including EPSDT

5.10.5.3.4 HCBS waiver services

5.10.5.3.5 Capitated Behavioral Health Benefit

5.10.5.3.6 Claims and billing procedures

5.10.5.4 The Contractor shall inform Network Providers of key Department contractors, their roles and responsibilities, including:

5.10.5.4.1 Business Intelligence Data Management Agency

5.10.5.4.2 Colorado Medicaid's fiscal agent

5.10.5.4.3 Enrollment broker

5.10.5.4.4 Pharmacy Benefit Management System

5.10.5.4.5 Utilization Management contractor

5.10.5.4.6 Oral Health contractor

5.10.5.4.7 Non-Emergent Medical Transportation administrators

5.10.5.4.8 Healthy Communities

5.10.5.4.9 Case Management Agencies

5.10.5.4.10 Community Center Boards

5.10.5.4.11 Single Entry Points

5.10.5.4.12 Nurse Advice Line

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

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

5.10.5.7 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:

5.10.5.7.1 Medicaid provider enrollment

5.10.5.7.2 Member eligibility and coverage policies

5.10.5.7.3 Service authorization and referral

5.10.5.7.4 Member and PCMP assignment and attribution

5.10.5.7.5 PCMP designation

5.10.5.7.6 Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits

5.10.5.8 The Contractor shall assist any Program provider who contacts the Contractor, including providers not in the Contractor's region who need assistance determining which Members are attributed to their practice. The Department will provide data to the Contractor on all Members for this purpose.

5.10.5.9 The Contractor shall use, and recommend to Network Providers, medical management, clinical and operational tools to ensure optimal health outcomes and control costs for Members. The suite of tools and resources should offer a continuum of support for Network Providers, specialists, and ancillary Medicaid providers. Examples of these types of tools are listed in Appendix J Practice Support Tools and Resources.

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

5.10.6 Provider Training

5.10.6.1 The Contractor shall, at a minimum, develop trainings based on subject matter expertise and host forums for ongoing training regarding the Program and the services the Contractor offers.

5.10.6.2 The Contractor shall offer training to its Network Providers at least every six (6) months on the following topics:

5.10.6.2.1 Colorado Medicaid eligibility and application processes

5.10.6.2.2 Medicaid benefits

5.10.6.2.3 Access to Care standards

5.10.6.2.4 EPSDT

5.10.6.2.5 The Contractor's Population Health Management Plan (see Section 5.11 for more information),

5.10.6.2.6 Use and proper submission of the Colorado Client Assessment Record for Members (CCAR) or the current Colorado Office of Behavioral Health's data collection tool for mental health and substance use disorders. (Appendix K CCAR)

5.10.6.2.7 Cultural responsiveness

5.10.6.2.8 Member rights, Grievances, and Appeals

5.10.6.2.9 Quality improvement initiatives, including those to address population health

5.10.6.2.10 Other trainings identified in consultation with the Department

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

5.10.7 Data Systems and Technology Support

5.10.7.1 The Contractor shall support providers in implementing and utilizing health information technology (HIT) systems and data.

5.10.7.2 The Contractor shall educate and inform Network Providers about the data reports and systems available to the providers and the practical uses of the available reports.

5.10.7.3 The Contractor shall make available technical assistance and training for Network Providers on how to use the following HIT systems:

5.10.7.3.1 Contractor's Care Coordination Tool

5.10.7.3.2 The BIDM

5.10.7.3.3 The interChange (MMIS)

5.10.7.3.4 Office of Behavioral Health's CCAR data collection tool

5.10.7.3.5 Multi-payer data aggregator tool for SIM and CPC practices

5.10.7.3.6 PEAK website and PEAKHealth mobile app

5.10.7.3.7 Regional health information exchange

5.10.7.3.8 Electronic consultation and referral tools

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

5.10.7.4.1 Provide practice-level data/reports

5.10.7.4.2 Assist providers with data analysis and reporting

5.10.7.4.3 Train practices on how to utilize data to:

5.10.7.4.3.1 Improve care for Members with chronic conditions

5.10.7.4.3.2 Implement population health strategies

5.10.7.4.3.3 Understand how their practice is performing on key performance indicators and other health outcome measures

5.10.7.4.3.4 Identify Members requiring Care Coordination

5.10.7.4.3.5 Identify Members who require additional services

5.10.7.4.4 The Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the PCMPs (both behavioral health claims from the Contractor's internal system and physical health claims data from the Department).

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

5.10.7.4.5 The Contractor shall facilitate clinical information sharing by supporting Network Providers in connecting electronic health records (EHRs) with the regional health information exchange (HIE) for exchanging clinical alerts and clinical quality measures (CQM) data.

5.10.7.4.5.1 The Contractor shall promote the use of Office of the National Coordinator for Health Information Technology (ONC) Interoperability Standards for PCMP EHR systems, to improve data exchange. These standards can be found at https://www.healthit.gov/policy-researchers-implementers/interoperability.

5.10.7.4.5.2 The Contractor shall conduct a Health Information Exchange Connectivity Assessment across their network of providers and report their findings to the Department, annually.

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

5.10.8 Practice Transformation

5.10.8.1 The Contractor shall offer practice transformation support to Network Providers interested in improving performance as a Medical Home and participating in alternative payment models, including the Department's Primary Care Alternative Payment Methodology. Practice transformation efforts may include activities such as: coaching practices in Team-based Care, improving business practices and workflow, increasing physical and behavioral health integration, and use of lay health workers.

5.10.8.2 The Contractor shall identify the existing strengths of a Network Provider and partner with the interested Network Provider to design and implement practice transformation strategies that build on these strengths and support the Network Provider in achieving its individualized practice goals.

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

5.10.8.4 The Contractor shall support Network Providers in increasing efficiencies and cost management at both the practice and the health system level by coaching providers to reduce the utilization or delivery of low-value services and supporting the identification and analysis of service overutilization.

5.10.8.5 The Contractor shall partner with practices to establish feasible transformation goals that best fit a practice's overall operational strategy. Based on the practice's goals, the Contractor shall develop a practice transformation plan to:

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

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

5.10.8.5.3 Provide technical assistance, tools and resources as appropriate.

5.10.8.6 The Contractor shall use existing practice transformation organizations in the region and the state and coordinate with existing practice transformation efforts, when appropriate, to reduce duplication of efforts and overburdening practices.

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

5.10.9 Financial Support

5.10.9.1 The Contractor shall make administrative/performance payments directly to PCMP Network Providers to support the provision of Medical Home level of care and to incentivize improved outcomes. The Contractor's payments will be in place of payments previously paid directly by the Department to the PCMP.

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

5.10.9.3 Administrative Payments

5.10.9.3.1 The Contractor shall distribute, in aggregate, at least thirty percent (30%) of the Contractor's administrative PMPM payments received from the Department to their PCMP network and Health Neighborhood.

5.10.9.3.2 The Contractor shall offer PCMPs the option of receiving, at a minimum, a standard $2 PMPM. The Contractor may work with providers to design different value-based payment arrangements that may exceed $2.

5.10.9.3.3 The Contractor shall provide the Department with a detailed reporting of the payment arrangements made with Network Providers in the Provider Payment Report, as well as report administrative payments made in the Quarterly Financial Report.

5.10.9.3.4 The Contractor shall work with Network Providers to develop a strategy to evolve administrative payments over the course of the Contract by tying a greater proportion of the dollars to value and aligning with other Department alternative payment methodologies.

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

5.10.9.3.6 The Contractor shall document the administrative payment strategy for Network Providers and the Department and will submit the document strategy for review and discussion at the Operational Learning Collaborative.

5.10.9.4 Pay for Performance

5.10.9.4.1 The Contractor shall share incentive payments earned for performance with PCMP Network Providers and other Health Neighborhood participants as appropriate. The Contractor has the flexibility to design innovative approaches to distribute funds in a way that maximizes performance at the provider-level.

5.10.9.4.2 The Contractor shall provide the Department with a summary of the pay-for-performance arrangements negotiated with providers in the Provider Payment Report.

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

5.10.10 Deliverables

5.10.10.1 DELIVERABLE: All Contractor-developed provider materials and trainings related to the Accountable Care Collaborative Program or Colorado Medicaid documents and provider contact plans

5.10.10.1.1 DUE: Ten (10) Business Days from the date the materials or plans are requested by the Department; and ten (10) Business Days from the request by the Department to update documents.

5.10.10.2 DELIVERABLE: Practice Support Plan

5.10.10.2.1 DUE: Thirty (30) days after the Contract Effective Date and then annually, on July 31.

5.10.10.3 DELIVERABLE: Health Information Exchange Connectivity Assessment

5.10.10.3.1 DUE: Annually, on July 31.

5.10.10.4 DELIVERABLE: Provider Payment Report

5.10.10.4.1 DUE: Thirty (30) days after the Contract Effective Date and then annually, on July 31.

5.11 PRIMARY CARE ALTERNATIVE PAYMENT METHODOLOGY (PRIMARY CARE APM)

5.11.1 The Department will be transforming its approach to primary care payment in the Fee-for-Service system by implementing the Primary Care Alternative Payment Methodology (Primary Care APM).

5.11.2 The Contractor shall play a key role in administering the Primary Care APM by certifying PCMP Practice Sites within their region eligible to participate in Track One.

5.11.3 The Contractor shall perform all of the following activities:

5.11.3.1 Assess each PCMP in their network using the Department's criteria and guidelines (Appendix L Primary Care APM) based on both on-site and desk reviews.

5.11.3.2 Certify those PCMPs that meet the Primary Care APM criteria based on the Contractor's assessment

5.11.3.3 Maintain all documentation of the assessment process and supporting information gathered regarding the PCMPs

5.11.3.4 Submit PCMP certification determination in a flat file or other agreed upon format to the Department.

5.11.3.5 Manage PCMP questions and concerns regarding the assessment and certification determination

5.11.3.6 Reassess every PCMP at a minimum of every three (3) years or based on a substantial change in a PCMP practice or at provider request.

5.11.4 Deliverables

5.11.4.1 DELIVERABLE: PCMP Certification Determination

5.11.4.1.1 DUE: By the 15th of each Month.

5.12 CAPITATED BEHAVIORAL HEALTH BENEFIT

5.12.1 The Contractor shall administer and deliver the Capitated Behavioral Health Benefit, which means that the Contractor shall:

5.12.1.1 Receive a Capitated Payment for each Member

5.12.1.2 Assume comprehensive risk for all covered inpatient and outpatient behavioral health services

5.12.1.3 Take full responsibility for providing, arranging for or otherwise taking responsibility for the provision of all Medically Necessary covered behavioral health services.

5.12.2 As the administrator of a capitated benefit, the Contractor shall employ strategic health care management practices described throughout this contract in administering the benefit, as well as creating financial incentives to drive quality care and having strong consumer experience protections.

5.12.3 The Contractor shall administer the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the Work outlined in this Contract thereby creating a seamless experience for Members and providers.

5.12.4 The Contractor shall demonstrate a commitment to the following principles in administering the Capitated Behavioral Health Benefit:

5.12.4.1 Recovery and Resilience: Treatment that supports Members in making positive changes in their behaviors so they can improve their health and life outcomes. Positive changes are achieved by sharing information, building skills, and empowering Members to make changes by leveraging individual strengths and protective factors. The benefits of recovery and resilience principles extend across ages and settings and can be particularly helpful for low-income children.

5.12.4.2 Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

5.12.4.3 Least Restrictive Environment: The provision of community-based supports and services that enable individuals with serious mental illness and other disabilities to live in the community to the greatest extent possible and as appropriate.

5.12.4.4 Culturally Responsive: Providers and provider staff deliver effective, understandable, and respectful care in a manner compatible with Members' cultural health beliefs, practices and preferred language.

5.12.4.4.1 The Contractor shall develop policies and procedures (as needed) on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter.

5.12.5 Covered Services.

5.12.5.1 The Contractor shall ensure access to care for all Members in need of Medically Necessary covered mental health and substance use disorder services in accordance with 10 CCR 2505-10 8.076.1.8. The Capitated Behavioral Health Benefit does not include behavioral services covered in 1915(c) waivers for individuals with intellectual and developmental disabilities.

5.12.5.2 The Contractor shall have a network to provide the Medically Necessary covered services as detailed in Section 5.12.5. and Appendix M Capitated BH Benefit Covered Services., including services identified under the federal Early and Periodic Screening Diagnostic and Treatment (EPSDT) program (42 C.F.R. § 441.50-441.62 and 10 CCR 2505-10 8.280).

5.12.5.3 The Contractor shall provide covered services in multiple Community-based venues to increase accessibility and improve outcomes. Treatment sites may include but are not limited to schools, PCMP Practice Sites, homeless shelters, skilled nursing and assisted living residences, and Members' homes.

5.12.5.4 In addition to the State Plan Services included in the Capitated Behavioral Health Benefit listed below, the Department now allows and encourages the provision of up to six (6) sessions of low-acuity behavioral health services in a primary care setting per episode of care. (Appendix R Low-acuity BH Services in Primary Care). These services will be reimbursed Fee-for-Service when billed by the primary care provider.

5.12.5.5 State Plan Services

5.12.5.5.1 *Individual psychotherapy*: One-to-one therapeutic contact with a Member for at least 30 minutes but not to exceed two hours.

5.12.5.5.2 *Individual brief psychotherapy*: Therapeutic contact with one Member up to and including 30 minutes.

5.12.5.5.3 *Group psychotherapy*: Therapeutic contact with more than one Member, up to and including two hours.

5.12.5.5.4 *Family psychotherapy*: Face-to-face therapeutic contact with a Member and family Member(s), or other persons significant to the Member, for improving Member-family functioning.

5.12.5.5.5 *Behavioral health assessment*: Face-to-face clinical assessment of a Member by a behavioral health professional that determines the nature of the Member's problem(s); factors contributing to the problem(s); a Member's strengths, abilities and resources to help solve the problem(s); and any existing diagnoses.

5.12.5.5.6 *Medication management*: Monitoring of medications prescribed and consultation provided to Members by a physician or other medical practitioner authorized to prescribe medications as defined by state law, including associated laboratory services as indicated.

5.12.5.5.7 *Outpatient day treatment*: Therapeutic contact with a Member in a structured, non-residential program of therapeutic activities lasting more than 4 hours but less than 24 hours per day, including associated laboratory services as indicated.

5.12.5.5.8 *School-based services*: State Plan outpatient behavioral health services provided to pre-school and school-aged children and adolescents on site in their schools, with the cooperation of the schools.

5.12.5.5.9 *Targeted case management*: Medically Necessary services to assist and support a Member in gaining access to or to develop his/her skills for gaining access to needed medical, social, educational, and other services essential to meeting basic human needs, as appropriate.

5.12.5.5.10 *Rehabilitative services*: Any remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of behavioral health symptoms and restoration of a recipient to his/her best possible functional level.

5.12.5.5.11 *Substance use disorder assessment*: An evaluation designed to determine the most appropriate level of care, based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug/alcohol use, abuse or dependence and related problems, and the comprehensive treatment needs of a Member with a drug or alcohol diagnosis.

5.12.5.5.12 *Alcohol/drug screen counseling*: Substance use disorder counseling services are provided along with screening to discuss results with a Member.

5.12.5.5.13 *Medication-assisted treatment*: Administration of Methadone or another approved controlled substance to an opiate dependent Member for the purpose of decreasing or eliminating dependence on opiate substances.

5.12.5.5.14 *Social ambulatory detoxification*: services are defined as services relating to detoxification including, but not limited to, the following:

5.12.5.5.14.1 Physical assessment of detox progression including vital signs monitoring.

5.12.5.5.14.2 Level of motivation assessment for treatment evaluation. Motivation is considered to be related to the probability that a Member will enter into, continue, and adhere to a specific change strategy.

5.12.5.5.14.3 Provision of daily living needs (includes hydration, nutrition, cleanliness and toiletry).

5.12.5.5.14.4 Safety assessment, including suicidal ideation and other behavioral health issues.

5.12.5.5.15 *Outpatient hospital services*: Outpatient hospital services are defined as a program of care in which the Member receives services in a health care facility, but does not remain in the facility 24 hours a day.

5.12.5.5.15.1 The Contractor is financially responsible for all Medicaid services associated with a Member's outpatient hospital treatment, including all psychiatric and associated medical and facility services, labs, x-rays, supplies, and other ancillary services, when the procedure(s) are billed on a UB-04 and ANSI 837-I X12 claim form, and the principal diagnosis is a covered psychiatric diagnosis.

5.12.5.5.15.2 The Contractor is financially responsible for all Medicaid services associated with a Member's outpatient hospital treatment, including all behavioral health and associated medical and facility services, labs, x-rays, supplies, and other ancillary services, when the procedure(s) is billed on a CMS-1500 and ANSI 837-P X12 claim form, and the principal diagnosis is a covered behavioral health diagnosis.

5.12.5.5.16 *Emergency and Post-Stabilization Care Services*

5.12.5.5.16.1 The Contractor shall cover and pay for emergency and post-stabilization care services as specified in 42 C.F.R. § 438.114(b) and 42 C.F.R. § 422.113(c).

5.12.5.5.16.2 Emergency Services are inpatient and outpatient hospital services that meet the following criteria:

5.12.5.5.16.2.1 Furnished by a provider that is qualified to administer these services according to 42 C.F.R. § 438.

5.12.5.5.16.2.2 Needed to evaluate or stabilize an emergency medical condition.

5.12.5.5.16.2.3 Services provided during a behavioral health emergency that involve unscheduled, immediate, or special interventions in response to a crisis situation with a Member, including associated laboratory services as indicated.

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

5.12.5.5.16.4 The Contractor is not responsible for outpatient emergency room services billed on a UB-04 for the treatment of a primary substance use disorder.

5.12.5.5.16.5 The Contractor is responsible for practitioner emergency room claims billed on a CO-1500 for the treatment of both substance use and mental health disorders.

5.12.5.5.16.6 The Contractor shall not refuse to cover treatment obtained under either of the following circumstances:

5.12.5.5.16.6.1 A Member had an emergency medical condition in which the absence of immediate medical attention would not necessarily have had the outcomes specified in the definition of emergency medical condition.

5.12.5.5.16.6.2 A representative of the Contractor instructs the Member to seek Emergency Services.

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

5.12.5.5.16.8 The Contractor shall not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

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

5.12.5.5.16.11 The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's network that are not pre-approved by the Contractor, but administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

5.12.5.5.16.11.1 The Contractor does not respond to a request for pre-approval within one (1) hour.

5.12.5.5.16.11.2 The Contractor cannot be contacted.

5.12.5.5.16.11.3 The Contractor and the treating provider cannot reach an agreement concerning the Member's care and a plan provider is not available for consultation. In this situation, the Contractor shall give the treating provider the opportunity to consult with a plan Provider and the treating provider may continue with care of the Member until a plan provider is reached or one of the criteria in 42 C.F.R. § 422.113(c)(3) is met.

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

5.12.5.5.16.13 The Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved ends when:

5.12.5.5.16.13.1 A plan provider with privileges at the treating hospital assumes responsibility for the Member's care.

5.12.5.5.16.13.2 A plan provider assumes responsibility for the Member's care through transfer.

5.12.5.5.16.13.3 The Contractor and the treating provider reach an agreement concerning the Member's care.

5.12.5.5.16.13.4 The Member is discharged.

5.12.5.5.16.14 Nothing in this section shall preclude the Contractor from conducting a retrospective review consistent with these rules regarding emergency and Post-Stabilization Care Services.

5.12.5.5.16.15 The Contractor is financially responsible for Emergency Services when the Member's primary diagnosis is psychiatric in nature, even when some physical health conditions are present or a medical procedure is provided.

5.12.5.5.16.16 The Contractor is not financially responsible for Emergency Services when the primary diagnosis is medical in nature even when procedures are provided to treat a secondary behavioral health diagnosis.

5.12.5.6 *Inpatient Psychiatric Hospital Services*

5.12.5.6.1 Inpatient Psychiatric Hospital Services are defined as follows:

5.12.5.6.1.1 For Members under 21 years old. A program of care for Members age twenty (20) and under in which the Member remains twenty-four (24) hours a day in a psychiatric hospital, or other facility licensed as a hospital by the state. Members who are inpatient on their twenty-first birthday are entitled to receive inpatient benefits until discharged from the facility or until their twenty-second birthday, whichever is earlier, as outlined in 42 C.F.R. § 441.151.

5.12.5.6.1.2 For adults ages 21 to 64 years. A program of psychiatric care in which the Member remains twenty-four (24) hours a day in a facility licensed as a hospital by the state, excluding state institutes for mental disease (IMDs).

5.12.5.6.1.3 For Members age 65 years and over. A program of care for Members age 65 and over in which the Member remains twenty-four (24) hours a day in an institution for mental diseases, or other facility licensed as a hospital by the state.

5.12.5.6.2 The Contractor's responsibility for all inpatient hospital services is based on the primary diagnosis that requires inpatient level of care and is being managed within the treatment plan of the Member.

5.12.5.6.2.1 The Contractor is financially responsible for the hospital stay when the Member's primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures (including labs and ancillary services).

5.12.5.6.2.2 The Contractor is not financially responsible for inpatient hospital services when the Member's primary diagnosis is physical in nature, even when the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis.

5.12.5.6.2.3 The Contractor is not financially responsible for inpatient hospital services when the Member's primary diagnosis is a substance use disorder that is evident at the time of admission.

5.12.5.6.3 The Contractor is financially responsible for a Member's admission to any free standing inpatient psychiatric facility, when the Member is presenting with psychiatric symptoms, for the purposes of acute stabilization, safety and assessment to determine whether or not the primary diagnosis occasioning the Member's admission to the hospital is a mental health disorder or substance use disorder.

5.12.5.6.3.1 The Contractor is financially responsible until a substance use disorder diagnosis is determined to be the primary diagnosis, at which point the Contractor shall no longer be responsible for continued acute stabilization, safety, and assessment services associated with that admission.

5.12.5.6.3.2 If a mental health disorder is determined to be the primary diagnosis, the Contractor shall be financially responsible for the remainder of the inpatient hospital services, as Medically Necessary in accordance with 10 CCR 2505-10 § 8.076.1.8. The assessment period shall generally not exceed seventy-two (72) hours.

5.12.5.7 Non-State Plan 1915(b)(3) Waiver) Services

5.12.5.7.1 The Contractor shall provide or arrange for the following 1915(b)(3) Waiver services to Members in at least the scope, amount and duration proposed in the Uniform Service Coding Standards (USCS) Manual. All 1915(b)(3) services provided to children/youth from age 0 to 21, except for respite and vocational rehabilitation, are included in the State Plan as Expanded EPSDT services.

5.12.5.7.1.1 *Vocational Services* – Services designed to assist adult and adolescent Members who are ineligible for state vocational rehabilitation services and require long-term services and supports in developing skills consistent with employment and/or in obtaining employment.

5.12.5.7.1.2 *Intensive Case Management* – Community-based services averaging more than one hour per week, provided to children and adults with serious behavioral health needs who are at risk of a more intensive twenty-four (24) hour placement and who need extra support to live in the community.

5.12.5.7.1.3 *Prevention/Early Intervention Activities* – Screening and outreach to identify at-risk populations, proactive efforts to educate and empower Members to choose and maintain healthy life behaviors and lifestyles that promote positive behavioral health. Services can be population-based, including proven media, written, peer advocate, and group interventions, and are not restricted to face-to-face interventions.

5.12.5.7.1.4 *Clubhouse and Drop-in Centers* – In clubhouses, Members utilize their skills for clerical work, data input, meal preparation, providing resource information or reaching out to fellow Members. Staff and Members work side-by-side, in a unique partnership. In drop-in centers, Members plan and conduct programs and activities in a club-like setting.

5.12.5.7.1.5 *Residential* – Any type of twenty-four (24) hour psychiatric care, excluding room and board, provided in a non-hospital, non-nursing home setting, where the Contractor provides supervision in a therapeutic environment. Residential services are appropriate for children, youth, adults and older adults who need twenty-four (24) hour supervised care in a therapeutic environment.

5.12.5.7.1.6 *Assertive Community Treatment (ACT)* – A service delivery model providing comprehensive, individualized, locally-based treatment to adult Members with serious behavioral health disorders. ACT services are provided by a multidisciplinary treatment team and are available twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days a year.

5.12.5.7.1.7 *Recovery Services* – Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports, and rights protection. Services may be provided at schools, churches or other Community locations. Services include, but are not limited to, peer counseling and support services, peer-run employment services, peer mentoring for children and adolescents, recovery groups, warm lines and advocacy services. Contractors shall utilize the competency-based guidelines included in the Peer Specialist Core Competencies Appendix of the Uniform Service Coding Standards (USCS) Manual, for training peer support specialists and recovery coaches.

5.12.5.7.1.8 *Respite Services* – Temporary or short-term care of a child, adolescent or adult provided by adults other than the birth parents, foster parents, adoptive parents, family Clients or caregivers with whom the Member normally resides, that is designed to give the usual caregivers some time away from the Member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

5.12.5.7.2 The Contractor shall regularly evaluate the effectiveness of the 1915(b)(3) Waiver services over the life of the contract. Any changes to the 1915(b)(3) Waiver services shall be proposed to and approved by the Department prior to implementation of the changes.

5.12.5.7.3 The Contractor shall submit a quarterly 1915(b)(3) Services Report to the Department. The report must list specific 1915(b)(3) Waiver services and the expenditure amounts associated with each service provided within that quarter. The Contractor shall submit this information in a Department approved template Appendix N 1915(b)(3) Services Report.

5.12.6 Service Limits

5.12.6.1 The Contractor shall provide covered services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

5.12.6.2 The Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

5.12.6.3 The Contractor is prohibited from arbitrarily denying or reducing the amount, scope or duration of a required service solely because of the diagnosis, type of illness or condition.

5.12.6.4 The Contractor may place appropriate limits on a service:

5.12.6.4.1 On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

5.12.6.4.2 For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose.

5.12.6.5 The Contractor shall inform Members (or their families/designated representative) by email, phone, or mail of the approved timeframe for select authorized services, such as residential treatment and inpatient hospitalizations, so that Members (or their representatives) are aware of how long the services have been authorized for and therefore may request a continuation of and/or additional services if needed. The Contractor shall record and document its notification of Members and families.

5.12.6.6 The Contractor shall establish clear and specific criteria for discharging Members from treatment. Criteria shall be included in Member materials and information. Individualized criteria for discharge agreed upon by Member and Provider shall be noted in the Member's health care record and modified, by agreement, as necessary.

5.12.6.7 The Contractor is not liable for any Covered Services provided prior to the date a Member is enrolled under this Contract or after the date of disenrollment.

5.12.6.8 The Contractor shall not hold a Member liable for Covered Services:

5.12.6.8.1 Provided to the Member, for which the Department does not pay the Contractor

5.12.6.8.2 Provided to the Member, for which the Department or Contractor does not pay the provider that furnishes the service under a contract, referral, or other arrangement

5.12.6.8.3 Furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the services directly

5.12.6.9 If the Contractor is unable to provide covered behavioral health services to a particular Member within its network, the Contractor shall adequately and timely provide the covered services out-of-network at no cost to the Member.

5.12.7 Service Planning, Coordination and Care Transitions

5.12.7.1 Based on the Member's needs and level of care required, the Contractor shall ensure they have procedures for the following:

5.12.7.1.1 Intake and Assessment: The Contractor shall ensure that each Member receives an individual intake and assessment appropriate for the level of care needed.

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

5.12.7.1.3 Transitions of Care: The Contractor shall provide continuity of care for Members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems.

5.12.7.1.4 Continued Services to Members: The Contractor shall comply with the state's transition of care policy to ensure the continued access to services during a transition from one RAE to another RAE as required in 42 C.F.R. § 438.62

5.12.8 Utilization Management

5.12.8.1 The Contractor shall ensure access to and appropriate utilization of covered behavioral health services by establishing and maintaining a utilization management program.

5.12.8.2 The Contractor shall designate an appropriately qualified clinician to direct the utilization management program.

5.12.8.3 The Contractor shall create, implement, and make publicly available written utilization management criteria and guidelines developed or adopted with involvement from practicing providers or nationally recognized standards.

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

5.12.8.5 If the Contractor determines that the Member does not meet standards of Medical Necessity for mental health and substance use disorder services, the Contractor shall inform the Member about how other appropriate services may be obtained, pursuant to federal Medicaid managed care rules, and coordinate within their system and the Health Neighborhood to refer them to the appropriate providers (e.g., CCBs, SEPs).

5.12.8.6 The Contractor shall adopt practice guidelines that consider the needs of its Members and are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

5.12.8.6.1 The Contractor shall adopt, and update periodically as appropriate, practice guidelines in consultation with contracting healthcare professionals.

5.12.8.6.2 The Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.

5.12.8.6.3 Decisions regarding utilization management, Member education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines.

5.12.8.7 The Contractor shall submit an annual Child Mental Health Treatment Act (CMHTA) Report that lists all the children/youth authorized for placement in a residential treatment setting by the Contractor under the CMHTA.

5.12.9 FQHC And RHC Encounter Reimbursement

5.12.9.1 The Contractor shall reimburse the FQHC or RHC by at least the encounter rate in accordance with 10 CCR 2505-10 § 8.700.6 and the Medicaid State Plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 § 8.700.3 for allowable costs identified in 10 CCR 2505-10 § 8.700.5. The Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

5.12.9.1.1 Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 § 8.700.6C.

5.12.9.1.2 The Department notifies the Contractor of the FQHC and RHC rates on a quarterly basis.

5.12.9.1.3 The Department conducts quarterly accuracy audits with FQHCs and RHCs. Should the Department recognize any discrepancy in FQHC or RHC payments (less than the full encounter rate), the Contractor is responsible for reimbursing the FQHC or RHC the difference of the encounter payment and the initial reimbursement amount. FQHC and RHC visits are defined in 10 CCR 2505-10 § 8.700.1.

5.12.9.2 If multiple behavioral health services are provided by an FQHC or RHC within one visit, the Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. The Contractor is required to pay the FQHC or RHC at least the encounter rate.

5.12.9.3 The Contractor shall submit the encounter data for FQHC and RHC visits to the Department per the specifications provided in Section 5.13.3.3.

5.12.9.4 The Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs and is required to complete the documentation located at https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms upon the Department's request.

5.12.10 Physician Incentive Plans

5.12.10.1 The Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

5.12.10.1.1 Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

5.12.10.2 Physician incentive plans may operate only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

5.12.10.3 If the Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the Contractor must ensure that the physician or physician group has adequate stop-loss protection.

5.12.11 Third Party Payer Liability

5.12.11.1 The Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing covered services under this Contract. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

5.12.11.1.1 Potential liable third parties shall include any of the sources identified in 42 C.F.R. § 433.138 relating to identifying liable third parties. The Contractor shall coordinate with the Department to obtain information from other state and federal agencies and the Contractor shall cooperate with the Department in obtaining information from commercial third party resources.

5.12.11.1.2 The Contractor shall, on a monthly basis, notify the Department's fiscal agent, by telephone or in writing, of any third party payers, excluding Medicare, identified by the Contractor in a Third Party Identification Report. If the third party payer is Medicare, the Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number. If the Member has health insurance coverage other than Medicare, the Contractor shall submit the following information:

5.12.11.1.2.1 Medicaid identification number

5.12.11.1.2.2 Member's social security number

5.12.11.1.2.3 Member's relationship to policyholder

5.12.11.1.2.4 Name, complete address, and telephone number of health insurer

5.12.11.1.2.5 Policy Member identification and group numbers

5.12.11.1.2.6 Policy Member's social security number

5.12.11.1.2.7 Policy Member's full name, complete address and telephone number

5.12.11.1.2.8 Daytime telephone number where Member can be reached

5.12.11.2 The Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by the Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.

5.12.11.3 The Contractor shall provide a quarterly report of all third party recovery efforts and amounts recovered by Medicaid Client ID, category of assistance and date of service to the Department. The report shall be provided on compact disc (CD) or by encrypted email, no later than thirty (30) days following the end of each quarter.

5.12.11.4 In addition to compensation paid to the Contractor under the terms of this Contract, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

5.12.11.5 The Contractor shall not restrict access to covered services due to the existence of possible or actual third party liability.

5.12.11.6 The Contractor shall inform Members, in its written communications and publications that Members shall comply with the Contractor's protocols, including using Providers within the Contractor's network, prior to receiving Non-emergency medical care. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to the Contractor or the Provider for payment or cost of the care or services.

5.12.11.7 The Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the third party, including using Providers within the third party's network, prior to receiving non-emergency medical care.

5.12.11.8 With the exception of Section 5.12.11.9 and except as otherwise specified in contracts between the Contractor and Network Providers, the Contractor shall pay all applicable co-payments, coinsurance and deductibles for approved covered services for the Member from the third party resource using Medicaid lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee-for-Service:

5.12.11.8.1 The sum of reported third party coinsurance and/or deductible or

5.12.11.8.2 The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

5.12.11.9 The Contractor shall pay, except as otherwise specified in contracts between the Contractor and Network Providers, all applicable copayment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee-for-Service.

5.12.11.10 The Contractor shall also inform its Members, in its written communications and publications, that failure to follow the third party's protocols will result in a Member being liable for the payment or the cost of any care or any service that the third party would have been liable to pay except that, if the third party or the service provider substantively fails to communicate the protocols to the Member, the items or services the third party is liable for are non-reimbursable under the terms of this Contract and the Member is not liable to the provider.

5.12.11.11 The Contractor shall include information in the Contractor's Member handbook regarding its rights and the Member's obligations under this section of the Contract and 25.5-4-301, C.R.S.

5.12.12 **Medical Loss Ratio (MLR)**

5.12.12.1 The Contractor shall have a Medical Loss Ratio (MLR) of eighty-nine percent (89%).

5.12.12.2 The Contractor shall calculate a Capitated Behavioral Health Benefit MLR each SFY using the template provided by the Department.

5.12.12.2.1 The MLR is rounded to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

5.12.12.2.2 The MLR Target will be decreased by one percent (1%) for each quality measure target (MLR Quality Target) that the Contractor meets or exceeds (see Appendix X: Quality Target Table (under development)). The lowest possible Adjusted MLR Target is four percent (4%) lower than the MLR Target, or eighty-five percent (85%). If the Contractor does not meet any MLR Quality Targets, then the Adjusted MLR Target is equal to the MLR Target, eighty-nine percent (89%).

5.12.12.2.3 If the Contractor's MLR does not meet or exceed the Adjusted MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

5.12.12.2.3.1 Reimbursement amount shall equal the total amount of capitation payments received by the Contractor multiplied by the difference between the Contractor's MLR and the Adjusted MLR Target.

5.12.12.2.3.2 The Contractor shall reimburse the Department within thirty (30) days of the Department finalizing the MLR validation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to the Contractor of the amount due, pursuant to 10 CCR 2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

5.12.12.3 The MLR will be calculated according to the instructions provided on the MLR template and the guidance provided in 42 C.F.R. § 438.8.

5.12.12.3.1 The first annual measurement period will begin upon the start of the Operational Period of this Contract and end on June 30, 2019.

5.12.12.3.2 Subsequent annual measurement periods will align with the state fiscal year, beginning on July 1 and ending on June 30 of the subsequent calendar year.

5.12.12.3.3 The Contractor will allow for four (4) months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five (5) months.

5.12.12.3.4 The Department will validate the MLR after any annual adjustments are made. The Department will discuss with the Contractor any adjustments that must be made to the Contractor's calculated MLR.

5.12.12.3.5 The Contractor must submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can validate the MLR. See Section 5.13.3.3 Behavioral Health Encounter Data Reporting and Appendix U Medical Loss Ratio (MLR) Calculation Template.

5.12.12.3.6 The Contractor's Medical Spend will be verified using both encounter data submitted through the state's Colorado interChange, as well as audited supplemental data provided in the Contractor's annual financial reporting.

5.12.13 Medicaid Payment in Full

5.12.13.1 Except as allowed in this Contract, the Contractor shall not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf, for Covered Services provided pursuant to this Contract.

5.12.13.2 Except as allowed in this Contract, the Contractor shall ensure that all of its Subcontractors and Network Providers do not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf other than the Contractor, for covered services provided pursuant to this Contract.

5.12.13.3 This section shall not be construed to limit the ability of any of the Contractor's Subcontractors or Network Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against the Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Network Provider and the Contractor.

5.12.13.4 This provision shall survive the termination of this Contract, for authorized services rendered prior to the termination of this Contract, regardless of the reason for the termination. This provision shall be construed to be for the benefit of the Contractor's Members.

5.12.13.5 For fees or premiums charged by the Contractor to Members, the Contractor may be liable for penalties of up to $25,000 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.

5.12.14 As a precondition for obtaining federal financial participation for payments under this agreement, per 45 C.F.R. §§ 95.1 and 95.7, the Department must file all claims for reimbursement of payments to the Contractor with CMS within 2 years after the calendar quarter in which the Department made the expenditure. The Contractor and the Department will work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file the Contractor's claims or capitation payments within two (2) years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 C.F.R. § 95.19, no claims or capitations will be paid to the Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from the Contractor all claims and capitations paid to the Contractor for any period of time disallowed by CMS.

5.12.15 DELIVERABLES

5.12.15.1 DELIVERABLE: Utilization Management Program and Procedures

5.12.15.1.1 DUE: Thirty (30) days after the Contract Effective Date and thirty (30) days after any significant change is made.

5.12.15.2 DELIVERABLE: 1915(b)(3) Waiver Services Report

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

5.12.15.3 Child Mental Health Treatment Act (CMHTA) Report

5.12.15.3.1 DUE: Annually on September 1.

5.12.15.4 DELIVERABLE: Third Party Identification Report

5.12.15.4.1 DUE: Ten (10) business days following the reporting month.

5.12.15.5 DELIVERABLE: Third Party Recovery Report

5.12.15.5.1 DUE: Within thirty (30) days following the end of the reporting quarter.

5.13 DATA, ANALYTICS AND CLAIMS PROCESSING SYSTEMS

5.13.1 Central Role of Data and Analytics

5.13.1.1 The Contractor shall use data and analytics to successfully operate the Accountable Care Collaborative Program. Data and information are used for a range of management, coordination and care activities, such as process improvement, population health management, federal compliance, claims processing, outcomes tracking and cost control.

5.13.1.2 The Contractor shall understand the key cost drivers within its region and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

5.13.1.2.1 The Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

5.13.1.2.2 The Contractor shall incorporate risk adjusted utilization expectations into its analytic procedures as Members with more complex conditions and needs are expected to use more resources.

5.13.1.3 The Contractor shall possess the resources and capabilities to leverage existing data systems and analytics tools or create new ones as necessary to perform the Work, conscious to avoid the creation of duplicative systems.

5.13.1.4 The Contractor shall use existing tools provided by the Department and other available resources to establish performance benchmarks and monitor provider performance across key cost and utilization metrics.

5.13.1.4.1 Colorado interChange (MMIS)

5.13.1.4.1.1 The Contractor shall maintain an interface that enables the Contractor to use the Colorado interChange to retrieve eligibility, enrollment and attribution information for Members.

5.13.1.4.1.2 At a minimum, the Contractor shall have the capabilities to utilize and process HIPAA standard transactions, such as the 834 form.

5.13.1.4.2 Business Intelligence and Data Management (BIDM) System

5.13.1.4.2.1 The Contractor shall use BIDM, the Program's analytics system, to access Medicaid claims and encounter data for physical, behavioral and dental services. The BIDM will directly interface with existing and future Medicaid data systems (interChange, AxisPoint Vital (LTSS care coordination tool) and Pharmacy Benefit Management System) while building capacity to exchange health information with other data sources, including clinical data.

5.13.1.4.2.2 The Contractor shall have the capability to use data to create meaningful and actionable information, and interpret such information to provide leadership and guidance to providers, partners and the Department.

5.13.1.4.2.3 The Contractor shall access standard analytics and reports, including trended Key Performance Indicator data, nationally recognized quality and utilization measures, and cost data.

5.13.1.4.2.4 The Contractor shall design queries and searches it requires and interpret the results of the queries and searches it conducts.

5.13.1.4.2.5 The Contractor shall share with the Network Providers, the BIDM and with the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.

5.13.1.4.2.6 The Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern, and apply the information to make changes and improve the health of the Contractor's Members.

5.13.1.4.2.7 The Contractor shall support and encourage Network Provider use of the BIDM Web Portal.

5.13.1.5 The Contractor shall ensure that it consistently meets all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 C.F.R. Part 2, 45 C.F.R. §§ 160, 162 and 164, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/HITECH Act (P.L. 111-005), and State of Colorado Cyber Security Policies. See Colorado Cyber Security Policies at http://oit.state.co.us/ois/policies.

5.13.1.6 The Contractor shall control the use or disclosure of Protected Health Information (PHI) as required by the HIPAA Business Associate agreement or as required by law. No confidentiality requirements contained in this RFP shall negate or supersede the provisions of the HIPAA privacy requirements.

5.13.1.7 The Contractor shall submit a data governance policy for approval by the Department.

5.13.1.7.1 The Contractor's data governance policy shall describe in what circumstances the Contractor will allow other entities, including providers and Community organizations, full access to Member level data, including how behavioral health data will be shared.

5.13.1.7.2 The Contractor shall update the data governance policy annually.

5.13.1.7.3 The Contractor shall report on the status and results of these governance activities annually.

5.13.2 Systems the RAE Must Maintain

5.13.2.1 Care Coordination Tool

5.13.2.1.1 The Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. The Contractor shall make it available for use by providers and care coordinators not currently using another tool.

5.13.2.1.2 The Contractor shall ensure that the Care Coordination Tool:

5.13.2.1.2.1 Works on mobile devices

5.13.2.1.2.2 Supports HIPAA-compliant data sharing

5.13.2.1.2.3 Provides role-based access to providers and care coordinators

5.13.2.1.3 The Contractor shall ensure the Care Coordination Tool can collect and aggregate, at a minimum, the following information:

5.13.2.1.3.1 Name and Medicaid ID of Member for whom Care Coordination interventions were provided

5.13.2.1.3.2 Age

5.13.2.1.3.3 Gender identity

5.13.2.1.3.4 Race/ethnicity

5.13.2.1.3.5 Name of entity or entities providing Care Coordination, including the Member's choice of lead care coordinator if there are multiple coordinators

5.13.2.1.3.6 Care Coordination notes, activities and Member needs

5.13.2.1.3.7 Stratification level

5.13.2.1.4 The Contractor's Care Coordination Tool shall have the capacity to capture information that can aid in the creation and monitoring of a care plan for the Member, such as clinical history, medications, social supports, Community resources, and Member goals.

5.13.2.1.5 The Contractor shall collect and be able to report the information identified in Section 5.13.2.1.3 for its entire network. Although Network Providers and subcontracted Care Coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.

5.13.2.1.6 The Contractor shall work with the Department to plan for how the Care Coordination Tool can exchange data with other Department tools such as BIDM and the LTSS Case Management system.

5.13.2.2 Claims Processing System for Capitated Behavioral Health Benefit

5.13.2.2.1 The Contractor shall maintain a claims processing system to reimburse providers for covered services under the Capitated Behavioral Health Benefit, and produce encounter claims.

5.13.2.2.2 The Contractor's claims processing shall have the capability to process claims using the billing procedure codes specified in the Uniform Service Coding Standards (USCS) Manual. The USCS Manual can be found on the Department's website.

5.13.2.2.3 Behavioral Health Encounter Data Reporting

5.13.2.2.3.1 The Contractor shall submit all Encounter Data on all State Plan and 1915(b)(3) Waiver services included within the Capitated Behavioral Health Benefit electronically, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). It is the Contractor's responsibility to ensure that the quality and timeliness of its encounter data meets the state's standards.

5.13.2.2.3.2 The Contractor shall submit Encounter Data in the ANSI ASC X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837 format encounter claims, reflecting paid, adjusted or denied by the Contractor, shall be submitted via a regular monthly batch process. All encounter claims shall be submitted in accordance with the following:

5.13.2.2.3.2.1 Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

5.13.2.2.3.2.2 Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

5.13.2.2.3.2.3 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

5.13.2.2.3.3 The Contractor shall submit and determine the acceptability of all Encounter Data within 90 days of an adjudicated claim. If the Contractor is unable to make a submission during a certain month, the Contractor must notify the Department of the reason for the delay and the estimated date when the Department can expect the submission.

5.13.2.2.3.4 The Contractor must make an adjustment to encounter claims when the Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If the Department discovers errors or a conflict with a previously adjudicated encounter claim, the Contractor shall adjust or void the encounter claim within fourteen (14) calendar days of notification by the Department.

5.13.2.2.3.5 The Contractor shall submit accurate encounter claim no later than 120 days following the date on which the Contractor adjudicated a provider claim.

5.13.2.2.3.5.1 The Contractor shall submit monthly data certifications for all Encounter Data used for rate setting, in compliance with 42 C.F.R. § 438.604 and 438.606. Data certification shall include certification that data submitted is accurate, complete and truthful, and that all paid encounters are for covered services provided to or for enrolled Members.

5.13.2.2.3.6 The Contractor shall submit its raw Encounter Data, excluding data protected by 42 C.F.R. Part 2, to the Colorado All-Payer Claims Database (APCD) in accordance with the guidelines found in the most current version of the Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide found at http://www.colorado.gov/hcpf. The data submitted to the APCD will be used in the calculation of performance measures.

5.13.2.2.3.7 The Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change format requirements following consultation with the Contractor, and retains the right to make the final decision regarding format submission requirements.

5.13.2.2.3.8 The Contractor shall use enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. Such data transmissions and enrollment reports shall include:

5.13.2.2.3.8.1 HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction

5.13.2.2.3.8.2 HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction

5.13.2.2.3.8.3 HIPAA X12N 834 Daily Roster

5.13.2.2.3.8.4 HIPAA X12N 834 Monthly Roster: Generated on the first business day of the month

5.13.2.2.3.8.5 Colorado interChange Encounter Reconciliation Report

5.13.3 Deliverables

5.13.3.1 DELIVERABLE: Certified encounter data submission

5.13.3.1.1 DUE: Monthly

5.13.3.2 DELIVERABLE: Data Governance Policy and Activities Update

5.13.3.2.1 DUE: Annually on July 31

5.14 OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

5.14.1 Continuous Quality Improvement

5.14.1.1 The Contractor shall implement and maintain an ongoing comprehensive quality assessment and performance improvement program (Quality Improvement Program) that complies with 42 C.F.R. § 438.310-370.

5.14.1.2 The Contractor shall take into consideration the federal definition of quality when designing its program. The Centers for Medicare and Medicaid Services (CMS) defines quality as the degree to which the Contractor increases the likelihood of desired outcomes of its Members through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge and interventions for performance improvement.

5.14.1.3 The Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the PCCM Entity and PIHP.

5.14.2 Quality Improvement Program

5.14.2.1 The Contractor's Quality Improvement Program shall align with the Department's Quality Strategy and include population health objectives as well as clinical measures of quality care. Quality Improvement Program activities shall, at a minimum, consist of the following:

5.14.2.1.1 Performance improvement projects

5.14.2.1.2 Collection and submission of performance measurement data, including Member experience of care

5.14.2.1.3 Mechanisms to detect both underutilization and overutilization of services

5.14.2.1.4 Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department

5.14.2.1.5 Quality of care concerns

5.14.2.1.6 External Quality Review

5.14.2.1.7 Advisory committees and learning collaboratives

5.14.2.2 The Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how the Contractor plans to implement its Quality Improvement Program. The Contractor shall make reasonable changes to the Quality Improvement Plan at the Department's direction.

5.14.2.3 Upon Department approval, the Contractor shall implement the Quality Improvement Plan.

5.14.2.4 The Contractor shall submit an Annual Quality Report to the Department and/or designee, detailing the progress and effectiveness of each component of its Quality Improvement Program. The Contractor shall include the following in the report:

5.14.2.4.1 A description of the techniques the Contractor used to improve its performance

5.14.2.4.2 A description of the qualitative and quantitative impact the techniques had on quality

5.14.2.4.3 Opportunities for improvement

5.14.2.5 The Contractor shall publicly post its Annual Quality Report.

5.14.3 Performance Improvement Projects

5.14.3.1 The Contractor shall conduct Performance Improvement Projects designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

5.14.3.2 The Contractor shall complete Performance Improvement Projects annually to facilitate the integration of project findings and information into the overall quality assessment and improvement program, and to produce new information on quality of care each year.

5.14.3.3 The Contractor shall have a minimum of two (2) Performance Improvement Projects chosen in collaboration with the Department: one that addresses physical health (may include behavioral health integration into physical health) and one that addresses behavioral health (may include physical health integration into behavioral health).

5.14.3.3.1 The Contractor shall conduct Performance Improvement Projects on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a particular topic.

5.14.3.4 The Contractor shall have the capacity to conduct up to two (2) additional Performance Improvement Projects as required and identified by the Department and/or CMS after Year 1 of the Contract.

5.14.3.5 The Contractor shall ensure that Performance Improvement Projects include the following:

5.14.3.5.1 Measurement of performance using objective quality indicators.

5.14.3.5.2 Implementation of system interventions to achieve improvement in quality.

5.14.3.5.3 Evaluation of the effectiveness of the interventions.

5.14.3.5.4 Planning and initiation of activities for increasing or sustaining improvement.

5.14.3.6 The Contractor shall participate in an annual Performance Improvement Project learning collaborative hosted by the Department that includes sharing of data, outcomes, and interventions.

5.14.3.7 The Contractor shall submit Performance Improvement Projects for validation by the Department's External Quality Review Organization (EQRO) to determine compliance with requirements set forth in 42 C.F.R. § 438.350, and as outlined in External Quality Review Organization Protocol for Validating Performance Improvement Projects. These requirements include:

5.14.3.7.1 Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction

5.14.3.7.2 Mechanisms to detect both under-utilization and over-utilization of services

5.14.3.7.3 Mechanisms designed to assess the quality and appropriateness of care furnished to Members with special health care needs

5.14.3.7.4 Measurement of performance using objective valid and reliable quality indicators

5.14.3.7.5 Implementation of system interventions to achieve improvement in quality

5.14.3.7.6 Empirical evaluation of the effectiveness of the interventions

5.14.3.8 The Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report and when requested by the Department.

5.14.4 Performance Measurement

5.14.4.1 The Contractor shall participate in the measurement and reporting of performance measures required by the Department, with the expectation that this information will be placed in the public domain.

5.14.4.2 The Contractor shall work with the Department to develop measurement criteria, reporting frequency and other components. The Department will determine the final measurement criteria.

5.14.4.3 The Contractor shall provide data, as required, to enable the Department or its designee to calculate the performance measures, unless the performance measure is specifically calculated by the Department.

5.14.4.4 The Contractor shall support Network Providers to collect and report information required to calculate the performance measures.

5.14.4.5 The Contractor shall track their performance on identified measures monthly through the BIDM and other data resources as appropriate.

5.14.4.6 The Contractor shall have the opportunity to provide comments regarding any and all of the Department's documented calculation methodologies for pay for performance measures prior to the first distribution of funds.

5.14.4.7 The Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

5.14.4.8 Accountable Care Collaborative Pay for Performance

5.14.4.8.1 The Contractor shall participate in three (3) components of pay for performance created from $4 withheld from the Accountable Care Collaborative's base administrative funding.

5.14.4.8.1.1 Key Performance Indicators:

5.14.4.8.1.1.1 The Contractor shall work to improve performance for up to nine Key Performance Indicators (KPIs) in order to earn performance payments. The KPIs will consist of eight (8) measures defined by the Department, plus one (1) measure that the RAE can choose from a list of options offered by the Department.

5.14.4.8.1.1.2 The Department's eight (8) measures are:

5.14.4.8.1.1.2.1 Total cost of care – Risk adjusted measure of average per member per month costs for both physical and behavioral health

5.14.4.8.1.1.2.2 Emergency department visits for ambulatory sensitive conditions – Number of ED visits per thousand members within a rolling twelve (12) month period, using the SIM ambulatory sensitive conditions criteria

5.14.4.8.1.1.2.3 Wellness visits – Members of all ages and populations with at least 90 days of continuous program enrollment that have had a well visit within a rolling twelve (12) month period

5.14.4.8.1.1.2.4 Behavioral health engagement – Members engaged in behavioral health services delivered either in primary care settings or under the Capitated Behavioral Health Benefit within a twelve (12) month rolling period.

5.14.4.8.1.1.2.5 Prenatal care – Members with a prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of program enrollment and the gaps in enrollment during the pregnancy. The data source for the measure is claims.

5.14.4.8.1.1.2.6 Dental Visit – Percentage of Members with a dental visit within a rolling twelve (12) month period

5.14.4.8.1.1.2.7 Obesity – Rates of overweight and obesity as measured through the BRFSS or by CDPHE as part of Colorado's 10 Winnable Battles

5.14.4.8.1.1.2.8 Health Neighborhood – Hybrid measure of utilization of Colorado Medical Society's Primary Care-Specialty Care Compact (Appendix S CMS Care Compact) and number of electronic consultations made within a twelve (12) month period

5.14.4.8.1.1.3 The Contractor's incentive payment for each KPI will differ based on performance as follows:

5.14.4.8.1.1.3.1 Level 1 is improvement between one percent (1%) and five percent (5%)

5.14.4.8.1.1.3.2 Level 2 is improvement of five percent (5%) or greater

5.14.4.8.1.1.4 The Contractor shall choose one KPI from a list provided by the Department when available, to address a target population within the Contractor's region.

5.14.4.8.1.1.5 The Contractor shall be capable of working to achieve performance on other KPI measures based on new statewide initiatives and through consultation with the RAEs and stakeholders.

5.14.4.8.1.2 Flexible Funding Pool

5.14.4.8.1.2.1 The Contractor may be eligible to earn an additional performance payment from a flexible funding pool that will be created from any monies not distributed to the RAEs for KPI performance. The flexible funding pool will be used to reinforce and align evolving program goals and to focus Contractor attention on priority program outcomes.

5.14.4.8.1.2.2 The Contractor may receive payments from the flexible funding pool either to:

5.14.4.8.1.2.2.1 Reward the Contractor for relative performance in or more measures selected by the Department related to a priority Program goal or objective, such as increasing the number of Members with an evaluation and maintenance claim within (7) days of hospitalization.

5.14.4.8.1.2.2.2 Incentivize provider participation in a new state or federal initiative that aligns with the Accountable Care Collaborative, such as CPC+.

5.14.4.8.1.3 Public Reporting

5.14.4.8.1.3.1 The Contractor is responsible for improving network performance on core health and cost measures that will be reported publicly on a quarterly basis (See Appendix O Proposed Performance Measures for a list of proposed measures). The Public Reporting measures will be divided in the following way:

5.14.4.8.1.3.1.1 Clinical and Cost Measures: Reporting of HEDIS and other clinical and cost measures that align with SIM, CPC+, and other state and federal initiatives

5.14.4.8.1.3.1.2 Public Health and System Level Measures: Reporting of program goals where the RAE and Network Providers play a critical but perhaps not determinative role, such as obesity rates, suicide rates, and passive tobacco exposure.

5.14.4.8.1.3.1.3 Member experience of care as described in Section 5.14.5

5.14.4.9 Capitated Behavioral Health Benefit Pay for Performance

5.14.4.9.1 Capitation Rate Setting

5.14.4.9.1.1 The Contractor's rate shall be determined partially based on performance as described in the following steps.

5.14.4.9.1.1.1 The Contractor's rate will be set at the actuarially certified point estimate if the Contractor's meets or exceeds base performance standards on several base performance metrics Current base performance standards and metrics for the capitation payment are:

5.14.4.9.1.1.1.1 Suicide risk assessment for major depressive disorder in children and adolescents

5.14.4.9.1.1.1.2 Suicide risk assessment for major depressive disorder in adults

5.14.4.9.1.1.1.3 Hospital readmissions at 7, 30, and 90 days

5.14.4.9.1.1.1.4 Hospital readmissions at 180 days

5.14.4.9.1.1.1.5 Adherence to antipsychotics for individuals with schizophrenia

5.14.4.9.1.1.1.6 Penetration rates

5.14.4.9.1.1.1.7 Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication

5.14.4.9.1.1.1.8 Inpatient utilization

5.14.4.9.1.1.1.9 Emergency department utilization for a mental health condition

5.14.4.9.1.1.1.10 Follow-up appointments after emergency department visits for a mental health condition or alcohol and other drug dependence

5.14.4.9.1.1.2 If the Contractor does not meet the Department's base standards, the Contractor will be paid at a rate below the point estimate, yet within the range allowed by CMS under the federal managed care regulations.

5.14.4.9.1.1.3 The Contractor's rate may be set higher than the actuarially certified point estimate if the Contractor has met the base performance standards and has also met or exceeded performance on additional performance metrics point estimate. Current performance measures that must be met for the higher rate payment include:

5.14.4.9.1.1.3.1 Mental health engagement

5.14.4.9.1.1.3.2 Initiation of alcohol and other drug dependence treatment

5.14.4.9.1.1.3.3 Engagement in alcohol and other drug dependence treatment

5.14.4.9.1.1.3.4 Follow-up appointments with any practitioner within 7 and 30 days after hospital discharge for a mental health condition

5.14.4.9.1.1.3.5 Follow-up appointments with a licensed behavioral health practitioner within 7 and 30 days after hospital discharge for a mental health condition

5.14.4.9.1.2 Behavioral Health Incentive Payment

5.14.4.9.1.2.1 Subject to federal authority and available funding, the Contractor may earn up to a four percent (4%) Behavioral Health Incentive Payment in addition to the Contractor's monthly capitation payment.

5.14.4.9.1.2.2 In order to qualify the Behavioral Health Incentive Payment, the Contractor shall have ninety percent (90%) accuracy for all Encounter Data submitted to the Department.

5.14.4.9.1.2.3 Once qualified, the Contractor may earn a Behavioral Health Incentive Payment based on annual performance goals in one or more aspirational performance measures identified through a collaborative process.

5.14.5 Member Experience of Care

5.14.5.1 The Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor and Network Providers.

5.14.5.2 The Contractor shall use tools to measure Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, call center data and Grievance and Appeals data.

5.14.5.3 The Contractor shall fund, administer and report on the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (CG-CAHPS) annually for both adults and children to measure Member satisfaction with Network Providers. The Contractor shall work with the Department to customize the survey, develop a sampling methodology and administer the survey.

5.14.5.3.1 The Contractor shall comply with NCQA protocols for administering the CAHPS survey and collecting response data.

5.14.5.3.2 The Contractor shall conduct the survey with Members from large practices (1,500 Members or more).

5.14.5.3.3 The Contractor shall conduct the survey with small practices (less than 1,500 Members) based on a sampling methodology developed in collaboration with the Department.

5.14.5.3.4 The Contractor shall provide the raw data from the survey responses to the Department, the EQRO and CMS. The Department will analyze the response data and provide reports to the Contractor.

5.14.5.3.5 The Contractor shall share CAHPS survey results and data with their provider network.

5.14.5.4 The Contractor shall support the Department in administering the ECHO Survey for Behavioral Health developed by the Office of Behavioral Health among Members accessing behavioral health services at CMHCs. The Contractor shall follow NCQA protocols and specifications.

5.14.5.5 The Contractor shall inform the Department and share findings if they conduct any additional surveys of Members.

5.14.5.6 The Contractor shall use all survey results and data to inform their Quality Improvement Plan and identify and implement interventions.

5.14.5.6.1 The Contractor shall develop a corrective action plan when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is reported.

5.14.6 Mechanisms to Detect Overutilization and Underutilization of Services

5.14.6.1 The Contractor shall implement and maintain a mechanism to detect overutilization and underutilization of services, and to assess the quality and appropriateness of care furnished to Members, including Members with special health care needs. These mechanisms may incorporate those developed for the Contractor's Utilization Management program.

5.14.6.2 Client Over-Utilization Program (COUP)

5.14.6.2.1 The Contractor shall partner with the Department in administering the COUP for Members who meet the criteria for inappropriate over utilization of health care services.

5.14.6.2.2 Quarterly, the Department will give the Contractor a list of all the Members who have met the Department's overutilization criteria and were notified in writing of their overutilization.

5.14.6.2.3 The Contractor shall outreach and intervene with Members identified as meeting overutilization criteria in order to link the Members to appropriate and available services.

5.14.6.2.4 The Contractor shall monitor Members' utilization of services and pharmaceuticals, and coordinate ongoing care.

5.14.6.2.5 For Members who remain on the overutilization list after a period of intervention, the Contractor shall perform a clinical review to determine the appropriateness of restricting the Member to either one medical provider and/or one pharmacy (lock in).

5.14.6.2.5.1 The Contractor shall appear as an expert witness in a State Fair Hearing for a Member who has appealed lock-in status.

5.14.6.2.6 The Contractor shall recruit providers to serve as lock-in providers.

5.14.6.2.6.1 The Contractor shall educate providers on what it means to be a lock-in provider, as well as provide informational materials.

5.14.6.2.6.2 The Contractor shall provide technical assistance to providers who will serve as primary lock-in providers.

5.14.6.2.6.3 The Contractor shall submit a quarterly COUP Report containing information including, but not limited to, outreach attempts, health assessments, interventions, and primary care visits of Members meeting overutilization criteria.

5.14.7 Quality of Care Concerns

5.14.7.1 The Contractor shall investigate any alleged Quality of Care (QOC) concerns, which are defined as concerns raised by the Department or providers, or concerns discovered by the Contractor. Member complaints about care are not considered QOC concerns and should be processed as Grievances, unless the Department instructs otherwise.

5.14.7.1.1 The Contractor shall have a system for identifying and addressing all alleged QOC concerns.

5.14.7.2 When a QOC concern is raised, the Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following:

5.14.7.2.1 Send an acknowledgement letter to the originator of the QOC concern.

5.14.7.2.2 Investigate the QOC issue(s).

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

5.14.7.2.4 Send a QOC resolution letter to the originator of the QOC concern. This letter shall include, at a minimum:

5.14.7.2.4.1 Sufficient detail to foster an understanding of the QOC resolution

5.14.7.2.4.2 A description of how the Member's health care needs have been met

5.14.7.2.4.3 A contact name and telephone number to call for assistance or to express any unresolved concerns

5.14.7.2.5 Refer QOC issues to the Contractor's peer review committee, when appropriate.

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

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

5.14.7.2.8 Document the incident in a QOC file. This file shall include, at a minimum:

5.14.7.2.8.1 The name and contact information of the originator of the QOC concern.

5.14.7.2.8.2 A description of the QOC concern including issues, dates and involved parties.

5.14.7.2.8.3 All steps taken during the QOC investigation and resolution process.

5.14.7.2.8.4 Corrective action(s) implemented and their effectiveness.

5.14.7.2.8.5 Evidence of the QOC resolution.

5.14.7.2.8.6 A copy of the acknowledgement and resolution letters.

5.14.7.2.8.7 Any referral made by the Contractor to peer review, a regulatory agency or a licensing board or agency.

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

5.14.7.2.9 For QOC concerns involving Network Providers, the Contractor may use the process of its professional review committee, as set forth in Sections 12-36.5-104 and 12-36.5-104.4, C.R.S.

5.14.7.2.10 The Contractor shall submit a letter to the Department, upon request, that includes a brief description of the QOC concern, the efforts that the Contractor took to investigate the concern and the outcome of the review as determined by the Contractor.

5.14.7.2.10.1 The Contractor shall include a description of whether the issue was found to be a QOC issue and what action the Contractor intends to take with the Provider(s) involved.

5.14.7.2.10.2 The Contractor shall not include in its letter the names of the persons conducting the investigation or participating in a peer review process.

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

5.14.7.2.10.4 The Contractor shall send the complete letter within ten (10) Business Days of the Department's request. Upon request from the Contractor, the Department may allow additional time to investigate and report.

5.14.7.2.11 Notwithstanding any other provision of this Contract, the Contractor may not disclose any information that is confidential by law. After the letter is received by the Department, if there is a request for public disclosure pursuant to the Colorado Open Records Act at 24-72-203, C.R.S., the Department will assert any applicable exemptions and, if none apply, will petition the court pursuant to 24-72-204(6)(a), C.R.S. to prohibit disclosure.

5.14.7.2.12 The Contractor shall submit a quarterly report to the Department using an agreed upon format that includes a brief description of each QOC concern identified during the previous quarter, and the outcome of each review.

5.14.8 External Quality Review

5.14.8.1 Annually, the Contractor shall participate in an external independent Site Review and performance measure validation in order to review compliance with Department standards and Contract requirements. External quality review activities shall be conducted in accordance with federal regulations 42 C.F.R. § 438 and the CMS mandatory activity protocols.

5.14.8.2 The external quality review will include a review of the Contractor activities in its role as a PCCM Entity and in its role as a PIHP for the Capitated Behavioral Health Benefit. The review also includes the Contractor's administration of the Contract as an integrated program.

5.14.8.3 The annual external review may include, but is not limited to the following:

5.14.8.3.1 Medical Record review. For external review activities involving Medical Record abstraction, the Contractor shall be responsible for obtaining copies of the Medical Records from the sites in which the services reflected in the encounter occurred.

5.14.8.3.2 Performance improvement projects and studies

5.14.8.3.3 Surveys

5.14.8.3.4 Network adequacy during the preceding 12 months

5.14.8.3.5 Calculation and audit of quality and utilization indicators

5.14.8.3.6 Administrative data analyses

5.14.8.3.7 Review of individual cases

5.14.8.3.8 Care Coordination record review

5.14.8.3.9 Provider site visits

5.14.8.3.10 Encounter Data validation

5.14.8.4 The Contractor shall participate in the development and design of any external independent review studies to assess and assure quality of care. The final study specifications shall be at the discretion of the Department.

5.14.9 Advisory Committees and Learning Collaboratives

5.14.9.1 To ensure the Program is effectively serving Members and providers, the Contractor shall participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the Program overall and guiding the improvement of program performance.

5.14.9.2 Program Improvement Advisory Committees (PIAC)

5.14.9.2.1 The Contractor shall participate in both a statewide and regional PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and providers in the Program. Both PIACs shall include, at a minimum, the following stakeholder representatives:

5.14.9.2.1.1 Members

5.14.9.2.1.2 Members' families and/or caregivers

5.14.9.2.1.3 PCMPs

5.14.9.2.1.4 Behavioral health providers

5.14.9.2.1.5 Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities)

5.14.9.2.1.6 Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests

5.14.9.2.2 For the statewide PIAC, the Contractor shall:

5.14.9.2.2.1 Designate one (1) of the Contractor's Key Personnel to serve as a member of the PIAC and attend monthly meetings.

5.14.9.2.2.2 Nominate two (2) representatives from the Contractor's regional PIAC to serve as members of the statewide PIAC and ensure they consistently attend and participate in monthly meetings.

5.14.9.2.3 The Contractor shall create a Regional PIAC with the following responsibilities:

5.14.9.2.3.1 Review the Contractor's deliverables.

5.14.9.2.3.2 Discuss program policy changes and providing feedback.

5.14.9.2.3.3 Provide representatives for the statewide PIAC.

5.14.9.2.3.4 Review the Contractor's and Program performance data.

5.14.9.2.3.5 Review Member materials and providing feedback.

5.14.9.2.4 The Contractor's Regional PIAC shall:

5.14.9.2.4.1 Be directed and chaired by one of the Contractor's Key Personnel.

5.14.9.2.4.2 Have a formal, documented membership and governance structure.

5.14.9.2.4.3 Hold monthly meetings in a manner that supports the following:

5.14.9.2.4.3.1 One meeting every three months is held for Members and their family or caregivers.

5.14.9.2.4.3.2 One meeting every three months is held for providers and Community partners.

5.14.9.2.4.3.3 One meeting every three months brings all stakeholders together.

5.14.9.2.4.4 Open all scheduled meetings to the public.

5.14.9.2.4.5 Post the minutes of each meeting on the Contractor's website within thirty (30) days of each meeting.

5.14.9.2.4.6 Accommodate individuals with disabilities.

5.14.9.3 Quality Improvement Committee

5.14.9.3.1 The Contractor shall have its Quality Improvement Director participate in the Department's Quality Improvement Committee to provide input and feedback regarding quality improvement priorities, performance improvement topics, measurements and specifics of reporting formats and timeframes, and other collaborative projects.

5.14.9.4 Operational Learning Collaborative.

5.14.9.4.1 The Contractor shall participate in a monthly Department Operational Learning Collaborative to monitor and report on Contractor and Program activities including, but not limited to, the following.

5.14.9.4.1.1 Wellness activities

5.14.9.4.1.2 Provider payment models

5.14.9.4.1.3 Health Promotion and Population Stratification and Management

5.14.9.4.1.4 Member engagement

5.14.9.4.1.5 Health Neighborhood and Community development

5.14.9.4.1.6 Provider support and practice transformation

5.14.9.4.1.7 Data analytics

5.14.9.4.1.8 Care Coordination, including cross-agency, cross-system activities

5.14.9.4.1.9 Health information initiatives and technologies

5.14.9.4.1.10 Strategies used to address social determinants of health

5.14.9.4.1.11 Transitions of care, including hospital discharge and LTSS Members transitioning to the community

5.14.9.4.2 The Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

5.14.10 Ad Hoc Quality Reports

5.14.10.1 The Contractor shall provide to the Department or its agents any information or data relative to the Contract. In such instances, and at the direction of the Department, the Contractor shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested.

5.14.10.1.1 The Contractor shall have at least thirty (30) calendar days, or a timeframe mutually agreed upon between the Department and the Contractor, to fulfill such requests.

5.14.10.1.2 The Contractor shall certify that data and information it submits to the Department is accurate.

5.14.11 Deliverables

5.14.11.1 DELIVERABLE: Quality Improvement Plan

5.14.11.1.1 DUE: Annually, by the last Business Day in September.

5.14.11.2 DELIVERABLE: Annual Quality Report

5.14.11.2.1 DUE: Annually, by the last Business Day in September.

5.14.11.3 DELIVERABLE: Performance Improvement Projects

5.14.11.3.1 DUE: To be determined by the Department.

5.14.11.4 DELIVERABLE: CG-CAHPS Survey Raw Data

5.14.11.4.1 DUE: To be determined by the Department.

5.14.11.5 DELIVERABLE: QOC Report

5.14.11.5.1 DUE: Quarterly, by the 10th business day of the month following the end of the calendar quarter that the report covers.

5.14.11.6 DELIVERABLE: COUP Report

5.14.11.6.1 DUE: Quarterly, by the 10th business day of the month following the end of the calendar quarter that the report covers.

5.15 COMPLIANCE

5.15.1 The Contractor shall have a system in place for ensuring compliance with the Accountable Care Collaborative Program rules, Contract requirements, state and federal regulations and confidentiality regulations, and a program to detect and prevent fraud, waste and abuse. All aspects of the system shall be focused on providing high-quality Medically Necessary services in accordance with contract requirements.

5.15.2 The Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438.

5.15.3 The Contractor shall have a compliance program, documented in a Compliance Plan. The compliance program and plan shall be approved by the Contractor's Chief Executive Officer and Compliance Officer.

5.15.3.1 The Contractor shall submit its Compliance Plan to the Department for review and approval.

5.15.3.2 The Contractor shall review, and update as necessary, the compliance program and plan at least annually. Upon completion of its review, the Contractor shall notify the Department of whether it has updated its compliance program and plan.

5.15.3.3 If it has made any updates or changes, the Contractor shall submit the updated Compliance Plan to the Department for review and approval.

5.15.4 Inspection and Audits

5.15.4.1 The Department, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services Office of Inspector General, the Comptroller General and their designees shall have the right to inspect and audit any records or documents of the Contractor or its Subcontractors and may at any time inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted. Notwithstanding any other provision in this contract, the right of the Department, CMS, the U.S. Department of Health and Human Services Office of Inspector General, the Comptroller General and their designees shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

5.15.4.2 The Contractor shall allow CMS or its agent or designated contractor and the Department or its agent to conduct unannounced, on-site inspections for any reason.

5.15.4.2.1 In the event that right of access is requested, the Contractor and/or its Subcontractors or providers shall:

5.15.4.2.1.1 Make staff available to assist in any audit or inspection under the Contract.

5.15.4.2.1.2 Provide adequate space on the premises to reasonably accommodate Department, state or federal or their designees' personnel conducting all audits, Site Reviews or inspections.

5.15.4.3 All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the Contractor's, Subcontractor's or providers' provision of care.

5.15.4.4 The Contractor shall allow access to the Contractor's claims system and claims data by Department staff for program integrity activities.

5.15.4.5 In consultation with the Department, the Contractor shall participate in compliance monitoring activities and respond to any Department or designee request for information related to compliance monitoring, including Encounter Data analysis and Encounter Data validation (the comparison of Encounter Data with Medical Records). The Department may request other information or analyses needed for compliance monitoring.

5.15.4.6 The Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five (5) Business Days.

5.15.5 Fraud, Waste and Abuse

5.15.5.1 The Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall have a compliance program to implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

5.15.5.2 The fraud, waste and abuse compliance program shall include:

5.15.5.2.1 Written policies and procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements.

5.15.5.2.2 The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Program Officer and the board of directors.

5.15.5.2.3 The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under the Contract.

5.15.5.2.4 A system for training and education for the Compliance Officer, the organization's Key Personnel, and the organization's employees for the federal and state standards and requirements under the Contract.

5.15.5.2.4.1 This training shall be conducted in a manner that allows the Department to verify that the training has occurred.

5.15.5.2.5 Effective lines of communication between the Compliance Officer and the Contractor's employees.

5.15.5.2.6 Enforcement of standards through well publicized disciplinary guidelines.

5.15.5.2.7 Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract. The system shall also include:

5.15.5.2.7.1 Processes for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.

5.15.5.2.7.2 Processes to screen all provider claims, collectively and individually, for potential fraud, waste or abuse.

5.15.5.2.7.3 Processes to identify overpayments to providers, including but not limited to, instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.

5.15.5.2.7.4 Processes to recover overpayments to providers.

5.15.5.2.7.5 Processes to identify and report to the Department suspected instances of Medicaid fraud.

5.15.5.2.7.6 Processes to provide individual notices to all or a sample of Members who received services to verify and report whether services billed by providers were actually received by Members.

5.15.5.2.8 The Contractor shall require providers to report to the Contractor when they have received an overpayment, to return the overpayment to the Contractor, and to notify the Contractor in writing of the reason for the overpayment within sixty (60) calendar days after the date on which the overpayment was identified.

5.15.5.2.8.1 The Contractor shall have a process for Network Providers to report and return overpayments to the Contractor.

5.15.5.2.9 Fraud

5.15.5.2.9.1 The Contractor shall notify the Department when it identifies or suspects possible provider or Member fraud as the result of any activities in its performance of the Contract, including any Utilization Management or review activities. Suspected fraud includes identification of intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person, whether it constitutes possible criminal fraud under federal or state law or violation of federal or state civil false claims statutes.

5.15.5.2.9.2 Upon identification or suspicion of possible provider or Member fraud, the Contractor shall:

5.15.5.2.9.2.1 Immediately make a verbal report of suspected fraud or other findings described above to the Department.

5.15.5.2.9.2.2 Submit written documentation of the findings to the Department within three (3) Business Days.

5.15.5.2.9.3 The Contractor shall include the following information, at a minimum, in all verbal and written reports to the Department regarding any identified or suspected provider or Member fraud:

5.15.5.2.9.3.1 All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, in a mutually agreed upon format.

5.15.5.2.9.3.2 Identification of any affected claims that have been discovered. The Contractor shall provide any claims data associated with its report, in a mutually agreed upon format.

5.15.5.2.9.4 The Contractor shall update and resubmit any written reports if additional information is obtained related to the suspected fraud.

5.15.5.2.9.5 The Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when possible fraud is suspected without the approval of the Department.

5.15.5.2.9.6 The Contractor shall not take any action that might interfere with an investigation of possible fraud by the Department, the Medicaid Fraud Control Unit, or any other law enforcement entity. The Contractor shall assist the Department, the Medicaid Fraud Control Unit or any other law enforcement entity as requested with any preliminary or full investigation.

5.15.5.2.9.7 The Contractor shall temporarily suspend all review activities or actions related to any provider which the Contractor suspects is involved in fraudulent activity. The Contractor shall continue its investigation as requested by the Department.

5.15.5.2.10 Expert Assistance to Department and the Medicaid Fraud Control Unit

5.15.5.2.10.1 The Contractor shall provide expert assistance to the Department, its Recovery Audit Contractor, and the Medicaid Fraud Control Unit (MFCU), as requested by the Department, related to review of overpayments, abuse, suspension of payments, or termination of a Network Provider, or the investigation of possible fraud by a Network Provider.

5.15.5.2.10.2 The Contractor shall provide expert assistance that includes, but is not limited to, the following topics:

5.15.5.2.10.2.1 Any reports made pursuant to this section.

5.15.5.2.10.2.2 Any medical records review or Medical Necessity findings or determinations made pursuant to this Contract.

5.15.5.2.10.2.3 Provider treatment and business practices.

5.15.5.2.10.2.4 Provider billing practices and patterns.

5.15.5.2.10.2.5 The Contractor shall meet with the Department, its contractors or the MFCU to explain any reports or findings made pursuant to the section. It shall cooperate with and provide assistance with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the Program Integrity Section, the Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

5.15.5.2.11 Suspension of Payments Due to a Credible Allegation of Fraud

5.15.5.2.11.1 The Contractor shall suspend all, or a portion of, payments to a provider when requested by the Department to implement 42 C.F.R. § 455.23. A suspension of a portion of payments may be based upon a unit of the provider or a percentage of amounts due to the provider.

5.15.5.2.11.2 The Contractor shall provide a monthly report of payments which have been suspended by provider.

5.15.5.2.11.3 The Contractor shall release suspended payment amounts to the provider within one payment cycle when directed to do so by the Department.

5.15.5.2.11.4 The Contractor may, on its own initiative, suspend payment to any provider against whom there is a credible allegation of fraud, but only after consultation with the Department and the MFCU.

5.15.5.2.11.5 The Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

5.15.5.2.11.6 The Department may suspend payments to the Contractor if the Contractor is under investigation for a credible allegation of fraud.

5.15.5.2.12 The Contractor shall participate in joint meetings held by the Department and the MFCU to discuss issues related to fraud, abuse, and misuse of Medicaid funds and resources.

5.15.5.2.13 The Contractor shall temporarily suspend all review activities or actions related to any provider upon request of the Department.

5.15.5.2.14 The Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

5.15.5.3 Recoveries of Overpayments Made by Contractor

5.15.5.3.1 The Contractor shall comply with the Department policies related to recoveries of overpayments.

5.15.5.4 The Contractor, if it makes or receives annual payments under the contract of at least $5,000,000, shall have written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

5.15.6 Quality Improvement Inspection, Monitoring and Site Reviews

5.15.6.1 The Contractor shall enable and support the Department or its designee to conduct site reviews of the Contractor's, Subcontractors' or providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in its sole discretion to determine compliance with applicable Department regulations and the requirements of this Contract.

5.15.6.2 Site Reviews may include but are not limited to determining compliance with state and federal requirements, contracts and Provider agreements, Medicaid service provision and billing procedures, and Medicaid Bulletins and Provider Manuals. Contractor shall cooperate with Department site review activities to monitor Contractor performance.

5.15.6.3 The Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

5.15.6.4 An emergency or unannounced review may be required in instances where Member safety, quality of medical care, potential fraud or financial viability is at risk. The Department may determine when an emergency review is required in its sole discretion.

5.15.6.5 The Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

5.15.6.6 For routine Site Reviews, the Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted for mutually agreed upon dates for a site review. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to the Contractor at least three (3) weeks prior to the visit. The Contractor shall submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate the Department and/or designee's desk audit prior to the Site Review. The Contractor has a minimum of thirty (30) days to submit the required materials for non-emergency reviews.

5.15.6.7 The Contractor shall make available, to the Department and its agents for Site Review, all records and documents related to the execution of this Contract, either on a scheduled basis as noted elsewhere in this section, or immediately on an emergency basis. Delays in the availability of such documents and records may subject the Contractor to remedial actions, as specified in this Contract. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.

5.15.6.8 A written report of the Site Review will be transmitted to the Contractor within forty-five (45) days of the Site Review. The Contractor is allowed thirty (30) days to review the preliminary report and respond to the findings. The final report will indicate areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

5.15.6.9 The Contractor shall respond to any required actions, if necessary, with a corrective action plan within thirty (30) days of the final written report, specifying the action to be taken to remedy any deficiencies noted by the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until the Contractor is found to be in complete compliance. The Department will notify the Contractor in writing when the corrective actions have been completed, accepted and the Contractor is considered to be in compliance with Department regulations and this Contract.

5.15.6.9.1 The Department may extend the time frame for corrective action in its sole discretion. The Department may also reduce the time frame for corrective action if delivery of covered services for Members is adversely affected or if the time reduction is in the best interests of Members, as determined by the Department.

5.15.6.9.2 For corrective action plans affecting the provision of covered services to Members, the Contractor shall ensure that covered services are provided to Members during all corrective action periods.

5.15.6.9.3 Any data submitted by the Contractor to the Department or its agents after the last site visit day will not be accepted towards compliance with the visit in the written report. This data will only apply toward the corrective action plan.

5.15.6.10 The Site Review may include reviews of a sample of Network Providers to ensure that Network Providers have been educated and monitored by the Contractor about the requirements under this Contract.

5.15.6.11 In the event that the Site Reviewers wish to inspect a Network Provider location, Contractor shall assure that:

5.15.6.11.1 Network Providers make staff available to assist in the audit or inspection effort.

5.15.6.11.2 Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

5.15.7 Prohibitions

5.15.7.1 The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. The Contractor shall not pay a Network Provider for provider-preventable conditions, as identified in the State Plan. The Contractor shall ensure that Network Providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

5.15.7.1.1 The Contractor shall report all provider-preventable conditions to the Department on an annual basis in the Provider Preventable Conditions Report.

5.15.7.2 The Contractor shall ensure all Network Providers are enrolled with the state as Medicaid Providers and no payment is made to a Network Provider pursuant to this contract if a Network Provider is not enrolled with the state as Medicaid provider. This provision does not require the Network Provider to render services to Fee-for-Service beneficiaries.

5.15.7.3 The Department will not make payment to the Contractor, if the Contractor is:

5.15.7.3.1 An entity that could be excluded from under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

5.15.7.3.2 An entity that has a contract for the administration, management or provision of medical services, the establishment of policies, or the provision of operation support, for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act or an individual described in in the section on prohibited affiliations or that has been excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

5.15.7.3.3 An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

5.15.7.3.3.1 Any individual or entity excluded from participation in federal health care programs.

5.15.7.3.3.2 Any individual or entity that would provide those services through an excluded individual or entity.

5.15.7.3.4 The Contractor shall not pay a provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

5.15.7.3.4.1 The provider or Subcontractor is excluded from participation in federal health care programs.

5.15.7.3.4.2 The provider of Subcontractor has a relationship described in the section on prohibited affiliations.

5.15.7.4 Prohibited Affiliations

5.15.7.4.1 The Contractor is prohibited from having a relationship with an individual or entity that is excluded from participation in any federal health care program as described in Sections 1128 and 1128A of the Social Security Act.

5.15.7.4.2 The Contractor is prohibited from knowingly having a relationship with:

5.15.7.4.2.1 A director, officer, or partner who is (or is affiliated with a person/entity that is, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101) 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 or excluded from participation in federal health care programs.

5.15.7.4.2.2 A Subcontractor which is (or is affiliated with a person/entity that is, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101) 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 or excluded from participation in federal health care programs.

5.15.7.4.2.3 A person with ownership or more than five (5) percent of the Contractor's equity who is (or is affiliated with a person/entity that is, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101) 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 or excluded from participation in federal health care programs.

5.15.7.4.2.4 An employment, consulting, or other arrangement with an individual or entity for the provision of the contracted items or services who is (or is affiliated with a person/entity that is, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101) 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 or excluded from participation in federal health care programs.

5.15.7.4.2.5 A Provider which is (or is affiliated with a person/entity that is, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101) 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 or excluded from participation in federal health care programs.

5.15.7.4.3 The Contractor shall provide written disclosure to the Department of any prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs.

5.15.7.4.4 If the Department learns that the Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, the Department:

5.15.7.4.4.1 Must notify the Secretary of the noncompliance.

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

5.15.7.4.4.3 May not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

5.15.8 Screening of Employees and Contractors

5.15.8.1 The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

5.15.8.2 The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and Subcontractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid.

5.15.8.3 If the Contractor determines that one of its employees or Subcontractors has been excluded, then the Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery to the Department within five (5) Business Days of the date of discovery.

5.15.9 Reporting

5.15.9.1 The Contractor shall report and return an overpayment to the Department within sixty (60) calendar days of identifying capitation or other payments in excess of amounts specified in the contract.

5.15.9.2 The Contractor shall promptly notify the Department when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:

5.15.9.2.1 Changes in the Member's residence;

5.15.9.2.2 The death of a Member.

5.15.9.3 The Contractor shall report all adverse licensure or professional review actions it has taken against any provider, in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank and to the appropriate state regulatory board.

5.15.9.4 The Contractor shall immediately notify the Department when it receives information about a change in a provider's circumstances that may affect the provider's eligibility to participate in the managed care program or in Colorado Medicaid program, including a change in licensing of a provider, a change in ownership or control of a provider, elimination from the provider network, or the conviction of a crime related to the provider's involvement in any program under Medicare, Medicaid, or the Title XX services program of the Social Security Act.

5.15.9.5 The Contractor shall notify the Department, in writing, of its decision to terminate any existing Network Provider at least sixty (60) calendar days prior to the services terminating, unless the basis for termination is for quality or performance issues.

5.15.9.5.1 If the basis for termination is a quality or performance issue, the Contractor shall notify the Department in writing within two (2) Business Days of its decision to terminate the Network Provider. The Contractor shall submit with the notice of termination, a narrative describing how it intends to provide or secure the services after termination.

5.15.10 Fraud, Waste and Abuse Compliance Reporting

5.15.10.1 For all covered services included in this Contract, the Contractor shall submit a Fraud, Waste, and Abuse Compliance Report every six (6) months that contains the following:

5.15.10.1.1 All audits or reviews which have been started, are on-going or completed in the previous six (6) months conducted as part of its fraud, waste and abuse compliance program. The report shall include the Provider legal name, Trade name if any, NPI and location of the provider which reviewed or audited, the issue(s) being reviewed or audited, the amount of the overpayment identified if any, the amount recovered if any, the status of the review or audit, the start and end dates of services covered by the review or audit, the start date of the review or audit and the date of recovery if any.

5.15.10.1.2 All instances of suspected fraud discovered and reported to the Department during the past six (6) months. The report shall include Provider legal name, Trade name if any, NPI and location of the provider which reviewed or audited, the suspected fraud issue, the start and end dates of the services suspected to involve fraud, the approximate amount of the claims affected and the date of fraud report to the Department.

5.15.10.1.3 The number of notices sent to Members to verify and report whether services billed by providers were actually received by Members, the number of responses received, number of responses warranting further action, whether a review, audit was conducted or fraud report was made regarding responses warranting further action and the amount of overpayments recovered.

5.15.10.2 The Contractor shall annually provide a summary report for the past year with the same information as contained in the quarterly report.

5.15.11 Administrative Reporting

5.15.11.1 The Contractor shall provide an Administrative Report to the Department, upon the Department's request, covering the period directed by the Department.

5.15.11.2 The Contractor shall deliver the Administrative Report to the Department within ten (10) Business Days following the request by the Department for that report. The Department may create a fixed schedule for the Contractor's submission of the Administrative Report by delivering the schedule to the Contractor in writing. The Department may change or terminate any fixed schedule it creates by notifying the Contractor in writing of the change or termination.

5.15.11.3 The Administrative Report shall contain all information regarding the Contractor's staffing, expenses and revenues relating to the Work, as directed by the Department for the period that the report covers. This information may include, but is not limited to, all of the following:

5.15.11.3.1 Number of Full Time Equivalent staff per position category, as determined by the Department, and total salary expenditure for that position category.

5.15.11.3.2 Operating expenses broken out by category, as determined by the Department.

5.15.11.3.3 Number of staff that were newly hired and separated and number of vacant positions, broken out by position category, as determined by the Department.

5.15.11.3.4 Administrative revenues, such as payments by debt and interest revenues, broken out by source as directed by the Department.

5.15.11.3.5 Administrative expenditures, such as payments to Subcontractors and Providers, broken out by source as directed by the Department.

5.15.11.3.6 Remaining cash-on-hand at the end of the period.

5.15.12 Financial Reporting

5.15.12.1 To achieve the Accountable Care Collaborative's objective of greater accountability and transparency, the Contractor shall participate in a robust financial reporting program.

5.15.12.2 The Contractor shall submit financial information to the Department on both a quarterly and annual basis, and attend in-person quarterly meetings to review and discuss the Contractor's financial information as follows:

5.15.12.2.1 Quarterly submission of financial information shall include, but not be limited to, the following:

5.15.12.2.1.1 Quarterly internal financial statements, including balance sheet and income statement

5.15.12.2.1.2 Quarterly trial balance listing all account numbers, descriptions and amounts

5.15.12.2.1.3 Crosswalk and/or allocation schedule(s) to link the quarterly trial balance to the quarterly financial report

5.15.12.2.1.4 Quarterly financial report using a template that has been mutually agreed upon by the Contractor and the Department. The report shall contain a detailed accounting of the total revenue received from the Department during the quarter and how payments were spent, including but not limited to, the following information:

5.15.12.2.1.4.1 The amount and percentage of PMPM payments spent during the reporting period to support the following categories of work:

5.15.12.2.1.4.1.1 PCMP Network Provider support, with a break-down of administrative payments made to PCMPs based on the payment strategy used (PMPM or other payment arrangement)

5.15.12.2.1.4.1.2 Care Coordination, with a break-down of dollars spent on contracted Care Coordination and that provided by the Contractor

5.15.12.2.1.4.1.3 Practice support to include specific information about the types of practices supported

5.15.12.2.1.4.1.4 Administration

5.15.12.2.1.4.1.5 Network development

5.15.12.2.1.4.1.6 Community infrastructure and Health Neighborhood participants

5.15.12.2.1.4.1.7 Systems support and capital infrastructure investments

5.15.12.2.1.4.1.8 Subcontractors

5.15.12.2.1.4.1.9 The categories listed above may be expanded as a result of the process of developing the reporting template

5.15.12.2.1.4.2 A breakdown of how the PMPM payments were spent for each category of work

5.15.12.2.2 The Contractor shall include the following information, at a minimum, in the Contractor's annual submission of financial information to the Department:

5.15.12.2.2.1 Annual internal financial statements, including balance sheet and income statement

5.15.12.2.2.2 Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP). The audited annual financial statements must be certified by an independent public accountant and the Contractor's Chief Financial Officer or their designee.

5.15.12.2.3 The Contractor shall participate in quarterly meetings with the Department to formally present and review the quarterly financial reports submitted to the Department. These meetings will be held not more than 30 days after the submission of the report. The Contractor shall ensure that the CEO and CFO are in attendance at these meetings.

5.15.12.3 The Contractor shall submit the annual financial information in a template provided by the Department and modified as needed. The Department will provide 60 days advance notice to the Contractor prior to requiring the use of a modified template.

5.15.12.4 The Contractor shall submit other financial reports and information as requested by the Department or its designee within 30 days following the request.

5.15.12.5 The Contractor shall assist the Department in verifying any reported information upon the Department's request. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

5.15.12.5.1 Fact-checking

5.15.12.5.2 Auditing reported data

5.15.12.5.3 Performing site visits

5.15.12.5.4 Requesting additional information

5.15.12.6 If the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated report to the Department within ten (10) days from the Department's request for the updated report.

5.15.13 Health Insurance Providers Fee Reporting

5.15.13.1 In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 C.F.R. § 57 and required to file a form 8963, then the Contractor shall create and submit a Health Insurance Providers Fee Report to the Department that contains all of the following information:

5.15.13.1.1 A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).

5.15.13.1.2 The preliminary and final calculations of the fee from the IRS, even if the calculated fee was $0.00.

5.15.13.1.3 An allocation of the fee attributable to the Work under this Contract.

5.15.13.1.4 Any additional information related to the Health Insurance Providers Fee, as determined by the Department.

5.15.13.2 The Contractor shall deliver the Health Insurance Providers Fee Report for each year that it is required to file a form 8963 with the IRS.

5.15.14 Disproportionate Share and Graduate Medical Education Hospital Report

5.15.14.1 The Contractor shall submit data quarterly according to the specifications in Appendix Q GME Reporting. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer (CEO) or the Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to, the CEO or CFO.

5.15.15 Maintenance of Records

5.15.15.1 The Contractor shall ensure that all Subcontractors and providers comply with all record maintenance requirements of the Contract, as shown in Section X of Appendix D.

5.15.15.2 Notwithstanding any other requirement of this contract, the Contractor shall retain and require Subcontractors to retain, as applicable, enrollee Grievance and Appeal records in accordance with 42 C.F.R. § 438.416, base data in accordance with 42 C.F.R. § 438.5(c), MLR reports in accordance with 42 C.F.R. § 438.8(k), and the data, information, and documentation specified is 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610 for a period of no less than 10 years.

5.15.16 Notices and Disclosures

5.15.16.1 Security Breaches and HIPAA violations

5.15.16.1.1 In the event of a breach of the security of sensitive data the Contractor shall immediately notify the Department to report all suspected loss or compromise of sensitive data within five (5) Business Days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

5.15.16.1.2 Contractor shall report all HIPAA violations as described in the HIPAA BUSINESS ASSOCIATE ADDENDUM.

5.15.16.2 Ownership or Control Disclosures

5.15.16.2.1 The Contractor shall disclose to the Department, at the time of submitting a provider application, executing the Contract with the State, at Contract renewal or extension, within thirty-five (35) calendar days of a written request from the Department, and within thirty-five (35) calendar days after any change in ownership, the following information in a form to be provided by the Department:

5.15.16.2.1.1 The name and address of any individual or entity with an ownership or control interest in the Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

5.15.16.2.1.2 Date of birth and Social Security Number of any individual with an ownership or control interest in the Contractor.

5.15.16.2.1.3 Tax identification number of any corporation or partnership with an ownership or control interest in the Contractor, or in any subcontractor in which the Contractor has a five percent (5%) or more interest.

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

5.15.16.2.1.5 The name of any other Medicaid provider (other than an individual practitioner or group of practitioners), fiscal agent, or managed care entity in which an owner of the Contractor has an ownership or control interest.

5.15.16.2.1.6 The name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

5.15.16.3 Disclosure of Information on Persons Convicted of Crimes

5.15.16.3.1 Upon submitting a provider application, upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date on a written request by the Department, the Contractor shall disclose the identity of any person who:

5.15.16.3.1.1 Has an ownership or control interest in the Contractor, or who is a managing employee of the Contractor; and

5.15.16.3.1.2 Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX services program, or Title XXI of the Social Security Act.

5.15.16.4 Business Transaction Disclosures

5.15.16.4.1 The Contractor shall submit, within thirty-five (35) days of the date on a request by the Department or by the Secretary of the Department of Health and Human Services, full and complete information about:

5.15.16.4.1.1 The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the 12-month period ending on the date of the request; and

5.15.16.4.1.2 Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

5.15.16.5 Definitions Relating to Disclosures

5.15.16.5.1 Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

5.15.16.5.2 Group of practitioners means two (2) or more health care practitioners who practice their profession at a common location, whether or not they share common facilities, common supporting staff, or common equipment.

5.15.16.5.3 Indirect ownership interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in another entity.

5.15.16.5.4 Ownership interest means the possession of equity in the capital, stock, or profits of an entity.

5.15.16.5.5 Individual or entity with an ownership or control interest means an individual or entity that: has an ownership interest totaling five percent (5%) or more; has an indirect ownership interest equal to five percent (5%) or more; has a combination of direct and indirect ownership interests equal to five percent (5%) or more; owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five percent (5%) of the value of the property or assets of the other entity; is an officer or director of an entity that is organized as a corporation; or is a partner in an entity that is organized as a partnership.

5.15.16.5.6 Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation.

5.15.16.5.7 Subcontractor means an individual, agency, or organization to which an entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.

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

5.15.16.5.9 Wholly owned supplier means a supplier whose total ownership interest is held by the Contractor or by a person, persons, or other entity with an ownership or control interest in the Contractor.

5.15.17 Conflict of Interest

5.15.17.1 The Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

5.15.17.2 The Contractor shall submit a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest, within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.

5.15.17.3 The term "conflict of interest" means that:

5.15.17.3.1 The Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

5.15.17.3.2 The relationship between the third party and the Department is such that one party's interests could only be advanced at the expense of the other's interests.

5.15.17.3.3 A conflict of interest exists even if the Contractor does not use information obtained from one party in its dealings with the other.

5.15.18 Solvency

5.15.18.1 The Contractor shall notify the Department, with two (2) Business Days, of becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards specified in this Contract.

5.15.18.2 The Contractor shall not hold liable any Member for the Contractor's debts, in the event the Contractor becomes insolvent.

5.15.19 Subcontracts and Contracts

5.15.19.1 The Contractor shall disclose to the Department, within five (5) Business Days of the Department's request, copies of any existing subcontracts and Contracts with providers.

5.15.19.2 The Contractor shall ensure that no Member is billed by a Subcontractor or provider for any amount greater than would be owed if the Contractor provided the services directly or in violation of 25.5-4-301(1)(a)(I), (II) and (II.5), C.R.S.

5.15.20 Warranties and certifications

5.15.20.1 The Contractor shall, within five (5) Business Days, disclose to the Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of this Contract.

5.15.21 Actions Involving Licenses, Certifications, Approvals and Permits

5.15.21.1 The Contractor shall notify the Department, within two (2) Business Days, of:

5.15.21.1.1 Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Title 10, Article 16, C.R.S.

5.15.21.1.2 Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

5.15.21.1.3 Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

5.15.22 Deliverables

5.15.22.1 DELIVERABLE: Compliance Plan

5.15.22.1.1 DUE: Thirty (30) days after the Effective Date and annually on July 31.

5.15.22.2 DELIVERABLE: Suspected Fraud Report

5.15.22.2.1 DUE: Within three (3) business days of the Contactor's verbal report to the Department.

5.15.22.3 DELIVERABLE: Suspended Payments Report

5.15.22.3.1 DUE: On the last business day of each month in which the Contractor suspends payments.

5.15.22.4 DELIVERABLE: Notification of discovery of excluded employee or contractor

5.15.22.4.1 DUE: Within five (5) Business Days of the date of discovery.

5.15.22.5 DELIVERABLE: Notice of Subcontractor Termination.

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

5.15.22.6 DELIVERABLE: Fraud, Waste, and Abuse Compliance Report

5.15.22.6.1 DUE: Within forty-five (45) days of the end of the six (6) month reporting period and an annual summary on July 31.

5.15.22.7 DELIVERABLE: Provider and Member Fraud Report

5.15.22.7.1 DUE: Three (3) business days from the initial discovery of the fraud or abuse.

5.15.22.8 DELIVERABLE: Administrative Report

5.15.22.8.1 DUE: Within ten (10) business days following the Department's request.

5.15.22.9 DELIVERABLE: Quarterly Financial Information

5.15.22.9.1 DUE: No later than thirty (30) days from the end of the state fiscal quarter.

5.15.22.10 DELIVERABLE: Audited Annual Financial Statement

5.15.22.10.1 DUE: No later than six (6) months from the end of the fiscal year that the statement covers.

5.15.22.11 DELIVERABLE: Updated Financial Reports or Statements

5.15.22.11.1 DUE: Ten (10) days from the Department's request for the updated report or statement.

5.15.22.11.2 DELIVERABLE: Health Insurance Providers Fee Report

5.15.22.11.2.1 DUE: Annually, no later than October 1 of each year in which the Contractor filed a form 8963.

5.15.22.12 DELIVERABLE: Security and HIPAA Violation Breach Notification

5.15.22.12.1 DUE: Within five (5) Business Days of becoming aware of the breach

5.15.22.13 DELIVERABLE: Ownership or Control Disclosures

5.15.22.13.1 DUE: At the time of executing the Contract with the Department, at Contract renewal or extension, and within thirty-five (35) calendar days of either a change of ownership or a written request by the Department.

5.15.22.14 DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes

5.15.22.14.1 DUE: Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date of a written request by the Department.

5.15.22.15 DELIVERABLE: Business transaction disclosures

5.15.22.15.1 Within thirty-five (35) calendar days of the date of a request by the Department or by the Secretary of the Department of Health and Human Services.

5.15.22.16 DELIVERABLE: Conflict of Interest Disclosure Statement

5.15.22.16.1 DUE: Within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.

5.15.22.17 DELIVERABLE: Solvency Notification

5.15.22.17.1 DUE: Within two (2) Business Days of becoming aware of a possible solvency issue.

5.15.22.18 DELIVERABLE: Subcontracts and Provider Contracts

5.15.22.18.1 DUE: Within five (5) Business Days of the Department's Request.

5.15.22.19 DELIVERABLE: Notification of Discovery of Excluded Network Provider

5.15.22.19.1 DUE: Within five (5) Business Days of discovering the exclusion of the Network Provider.

5.15.22.20 DELIVERABLE: Notices and Disclosures Policies and Procedures

5.15.22.20.1 DUE: Within ten (10) Business Days of the Department's request.

5.15.22.21 DELIVERABLE: Warranty and Certification Notification.

5.15.22.21.1 DUE: Within five (5) Business Days of becoming aware of its inability to offer the warranty and certifications.

5.15.22.22 DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

5.15.22.22.1 DUE: Within two (2) Business Days of Contractor's notification.

5.15.22.23 DELIVERABLES

5.15.22.23.1 DELIVERABLE: Provider Preventable Conditions Report

5.15.22.23.1.1 DUE: Annually, on July 31 of each year.

5.15.22.23.2 DELIVERABLE: Disproportionate Share and Graduate Medical Education Report

5.15.22.23.2.1 DUE: Quarterly on July 31, October 31, January 31, and April 30.

5.16 START-UP AND CLOSEOUT PERIODS

5.16.1 The Contract shall have a Start-Up Period and a Closeout Period.

5.16.2 Start-Up Period

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

5.16.2.2 The Operational Start Date shall not occur until the Contractor has completed all requirements of the Start-Up Period, including the completion of the operational readiness review unless the Department provides written approval otherwise.

5.16.2.3 The Contractor shall not engage in any Work under the Contract, other than the Work described below in the Start-Up Period, prior to the Operational Start Date. The Department shall not be liable to the Contractor for, and the Contractor shall not receive, any payment for any period prior to the Operational Start Date under the Contract.

5.16.2.4 During the Start-Up Period, the Contractor shall complete all tasks required to do the Work on the Operational Start Date, such as:

5.16.2.4.1 Hire and train new staff

5.16.2.4.2 Establish infrastructure for data collection and exchanges, billing and reimbursement

5.16.2.4.3 Test system compatibility

5.16.2.4.4 Demonstrate adherence to security protocols

5.16.2.4.5 Set up provider networks and agreements

5.16.2.4.6 Develop Member and provider materials and education

5.16.2.4.7 Complete activities to fully transition the services described in the Contract from a prior contractor

5.16.2.4.8 Create Policy and Procedures Manual for systems and functions necessary for the Contractor to complete its obligations under the Contract.

5.16.2.4.9 Create the Business Continuity Plan described in Section 5.1.

5.16.2.4.10 Create the Communication Plan described in Section 5.1.

5.16.2.5 The Contractor shall create a Start-Up Plan that describes the steps, timelines and milestones necessary to complete the tasks required before the Operational Start Date, and plans to mitigate any risks to the start of operations for this Contract.

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

5.16.2.5.2 The Contractor shall provide weekly updates to the Department throughout the Start-Up Period that show the Contractor's status toward meeting the timelines and milestones outlined in the Start-Up Plan.

5.16.2.6 Readiness review. The Contractor shall participate in a readiness review in compliance with 42 C.F.R. § 438.66, completed at least three (3) months before the Operational Start Date. The readiness review consists of a desk audit and Site Review covering the following:

5.16.2.6.1 Administrative staffing and resources

5.16.2.6.2 Delegation and oversight of MCO, PIHP, PAHP or PCCM Entity responsibilities:

5.16.2.6.2.1 Provider communications

5.16.2.6.2.2 Grievance and Appeals

5.16.2.6.2.3 Member communication, services and outreach

5.16.2.6.2.4 Provider Network Management

5.16.2.6.2.5 Program Integrity/Compliance

5.16.2.6.2.6 Case management/Care Coordination/service planning

5.16.2.6.2.7 Quality improvement

5.16.2.6.2.8 Utilization review

5.16.2.6.2.9 Financial reporting and monitoring

5.16.2.6.2.10 Financial solvency

5.16.2.6.2.11 Claims management

5.16.2.6.2.12 Encounter data and enrollment information management

5.16.3 Closeout Period

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

5.16.3.2 This Closeout Period may extend past the termination of the Contract and the requirements of the Closeout Period shall survive termination of the Contract.

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

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

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

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

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

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

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

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

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

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

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

5.19.3.5.3. Deliverables

5.16.3.4 DELIVERABLE: Start-Up Plan

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

5.16.3.5 DELIVERABLE: Member Notifications

5.16.3.5.1 DUE: Thirty (30) days prior to termination of the Contract.

5.16.3.6 DELIVERABLE: Provider Notifications

5.16.3.6.1 DUE: Thirty (30) days prior to termination of the Contract.

5.16.3.7 DELIVERABLE: Closeout Plan

5.16.3.7.1 DUE: Thirty (30) days following the Effective Date

5.16.3.8 DELIVERABLE: Closeout Plan Update

5.16.3.8.1 DUE: Annually, by July 31 of each year.

SECTION 6.0 ADDITIONAL STATEMENT OF WORK ACTIVITIES

6.1.1 The Contractor shall perform the following activities as part of the Work when requested by the Department. The Contractor shall not perform any activities included in Section 6.0 without the Department issuing an option letter to add the funding associated with these activities.

6.2 WRAPAROUND PROGRAM FOR CHILDREN AND YOUTH WITH SIGNIFICANT MENTAL HEALTH CONDITIONS

6.2.1 The Contractor shall administer a Wraparound Program to improve the health, well-being, and functioning of children and youth with significant mental health conditions and their families, and should seek, when possible, to reduce potentially-preventable emergency room, inpatient, or residential child care facilities utilization.

6.2.2 The Contractor's Wraparound Program shall consist of high-fidelity Wraparound Care Coordination and parent/caregiver peer support in alignment with the state's System of Care and the evidence-based model detailed within the book *Building Systems of Care: A Primer* (2010).

6.2.3 Population Served

6.2.3.1 The Contractor shall administer the Wraparound Program for children and youth from birth to age twenty-one (21) who are assessed as likely to benefit from the Program and who meet all of the following Medical Necessity criteria:

6.2.3.1.1 The child or youth met at any time during the past 12 months the diagnostic criteria for Serious Emotional Disturbance (SED) or Serious and Persistent Mental Illness (SPMI) as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.) with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable condition.

6.2.3.1.2 The child's or youth's diagnosable disorder substantially interferes or limits the child's or youth's role or functioning in family, school, employment, relationships, or community activities.

6.2.3.1.3 The child or youth is taking multiple psychotropic medications outside of recommended guidelines and/or is identified as having a high likelihood of any of the following:

6.2.3.1.3.1 Placement in a Residential Child Care Facility;

6.2.3.1.3.2 A psychiatric hospitalization; or

6.2.3.1.3.3 Commitment in the Youth Corrections system.

6.2.3.1.4 The child or youth needs or receives multiple services from the same or multiple providers or state child serving systems (i.e., child welfare, juvenile justice, or special education) and needs a care planning team to coordinate services.

6.2.3.1.5 The person(s) with authority to consent to medical treatment for the child or youth voluntarily agrees to participate in the Wraparound Program. The assent of the child or youth who is not authorized under applicable law to consent to medical treatment is desirable but not required.

6.2.3.2 The Contractor may assess for appropriateness children or youth in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting who meet the Systems of Care Medical Necessity criteria described in Section 6.2.3.1 who are within 180 days of discharge.

6.2.3.3 The Contractor shall not administer the Wraparound Program for children or youth who are determined as not being likely to benefit from the Wraparound Program or who meet either of the following criteria:

6.2.3.3.1 The person(s) with authority to consent to medical treatment for the child or youth does not voluntarily consent to participate in Wraparound Program.

6.2.3.3.2 The child or youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family home environment or community setting with community-based supports.

6.2.3.4 The Contractor shall continue administering the Wraparound Program for children or youth who meet all of the following criteria:

6.2.3.4.1 The child or youth's clinical condition(s) continues to warrant the Wraparound Program in order to coordinate the child or youth's involvement with state agencies or multiple service providers.

6.2.3.4.2 Progress toward identified care plan goals have been documented.

6.2.3.5 The Contractor shall discontinue administering the Wraparound Program for children and youth who meet any of the following criteria:

6.2.3.5.1 The child or youth no longer meets the criteria for a significant mental health condition

6.2.3.5.2 The Child and Family Care Team determine the child or youth has met the care plan objectives and continued services are not necessary to prevent worsening of the child or youth's behavioral health condition.

6.2.3.5.3 Consent for treatment is withdrawn.

6.2.3.5.4 The child/youth and parent/caregiver are not engaged in treatment despite multiple documented attempts to address engagement.

6.2.3.5.5 The child/youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or community setting with community-based supports.

6.2.3.5.6 The youth turns 21 years old.

6.2.4 The Contractor shall submit to the Department a monthly Wraparound Program Enrollment Report that contains, at a minimum, the following information:

6.2.4.1 Name and Medicaid ID for all new Members enrolled in the Wraparound Program during the past month.

6.2.4.2 Name and Medicaid ID for all Members who remain enrolled in the Wraparound Program.

6.2.4.3 Name and Medicaid ID for all Members whose enrollment in the Wraparound Program was terminated during the past month.

6.2.5 The Contractor shall accept, monitor and report on all referrals of potentially eligible children and youth and the final determination. Referrals may come from the state's Crisis Hotline, child welfare, probation, Network Provider, school or other source.

6.2.5.1.1 In addition, the Contractor shall identify children and youth enrolled with the Contractor that might benefit from the Wraparound Program by examining past hospitalizations, overuse of the crisis system, and prescriptions for high levels of psychotropic medication.

6.2.5.2 The Department estimates that between 1,000 and 2,000 children and youth may be eligible and likely to participate in the Wraparound Program statewide.

6.2.6 Wraparound Program Network

6.2.6.1 The Contractor shall establish a Wraparound Program network of licensed CMHCs, residential treatment centers, and private practitioners that:

6.2.6.1.1 Are trained in high-fidelity Wraparound.

6.2.6.1.2 Have demonstrated experience with:

6.2.6.1.2.1 Strength-based, family-driven practice and service models

6.2.6.1.2.2 Sustained partnerships with child-serving organizations, such as schools, child welfare, youth and family service providers, faith institutions, etc.

6.2.6.1.3 Employ or have contracts with parent(s) and caregiver(s) of children and youth with significant mental health conditions who have been trained to provide peer support, system navigation, and other types of assistance to families who have youth with serious emotional disturbance.

6.2.7 Wraparound Program Activities

6.2.7.1 The Contractor shall provide, arrange for, or otherwise take responsibility for the provision of high-fidelity Wraparound Care Coordination and parent/caregiver peer support.

6.2.7.2 The Contractor shall ensure the delivery of a high fidelity Wraparound model as defined by the National Wraparound Implementation Center and measured by the most current version of the Wraparound Fidelity Index.

6.2.7.3 The Contractor shall ensure the provision of the four phases of the Wraparound Care Coordination process to ensure that every child/youth served has a family-driven, youth-guided team, facilitated by a dedicated care coordinator that plans and ensures access to needed behavioral health, medical, oral, social, educational, developmental, and other services and supports. The four phases of the Wraparound Care Coordination process are:

6.2.7.3.1 A comprehensive home-based assessment of Medical Necessity for Wraparound Program

6.2.7.3.2 Development and facilitation of a Child and Family Team

6.2.7.3.3 Creation of an individualized care plan

6.2.7.3.4 Monitoring and follow-up activities to ensure successful implementation of the individualized care plan

6.2.7.4 The Contractor shall ensure the Wraparound Care Coordination includes, at a minimum, the following activities:

6.2.7.4.1 A comprehensive home-based assessment of Medical Necessity for the Wraparound Program including utilization of the following tools:

6.2.7.4.1.1 Child and Adolescent Needs and Strengths (CANS) assessment tool

6.2.7.4.1.2 Strengths, Needs, Culture, Discovery Assessment (Systems of Care Assessment)

6.2.7.4.2 Development and facilitation of a Child and Family Team to identify the unique needs of the child and family and to develop treatment approaches to address those needs. The Child and Family Team shall include the child/youth, family/caregiver, natural supports (friends, neighbors, interested stakeholders), Wraparound care coordinator, treatment providers, and any relevant social service or education entities.

6.2.7.4.3 Creation and monitoring of an individual care plan.

6.2.7.4.4 Creation of crisis/safety plan(s).

6.2.7.4.5 Care Coordination, including, at a minimum, the following responsibilities:

6.2.7.4.5.1 Face-to-face meetings at least bi-weekly

6.2.7.4.5.2 Regular telephonic, electronic, and other contact with youth and parent/caregiver, at a minimum of one (1) time per week

6.2.7.4.5.3 Linkage and referrals for supports and services

6.2.7.4.5.4 Assistance with system navigation

6.2.7.4.5.5 Attendance at relevant treatment provider meetings, such as IEP and hospital discharges

6.2.7.4.5.6 Aftercare planning

6.2.7.4.6 Education, advocacy and support to youth and parent(s)/caregiver(s).

6.2.7.4.7 Individualized and family-driven interventions and/or supports for the youth and parent/caregiver.

6.2.7.4.8 Member outreach.

6.2.7.4.9 Documentation of contacts and interventions.

6.2.7.5 The Contractor shall ensure the provision of parent/caregiver peer support for those parents and caregivers who require additional assistance to more effectively support their child's/youth's recovery.

6.2.7.5.1 Parent/caregiver peer support is a structured, one-to-one, strength-based relationship between a trained parent/caregiver with lived experience and a parent/caregiver whose child/youth is currently engaged with the Wraparound Program. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning.

6.2.8 Wraparound Program Administration

6.2.8.1 The Contractor shall ensure the appropriate and cost effective administration of the Wraparound Program by:

6.2.8.1.1 Performing and/or reviewing eligibility assessments for the Wraparound Program

6.2.8.1.2 Recruiting trained Wraparound Program providers

6.2.8.1.3 Ensuring an adequate network of trained Wraparound care coordinators to meet the needs of all eligible children and youth in the Contractor's region.

6.2.8.1.4 Monitoring delivery of Wraparound Program activities and coordination of care for all active Members engaged in the Wraparound Program, including review of the statewide Systems of Care software program.

6.2.8.1.5 Ensuring Wraparound Program enrollees receive timely access to Medically Necessary services covered under the Accountable Care Collaborative, such as outpatient behavioral health therapy and intensive in-home therapy.

6.2.8.1.6 Facilitating data sharing across all treating providers and ensuring the completion of necessary consents and releases of information.

6.2.8.1.7 Continually monitoring Wraparound Program outcomes.

6.2.8.1.8 Reporting to the Department and Child Welfare and local Collaborative Management Programs on Wraparound Program utilization and referrals.

6.2.8.1.9 Collaborating with Community partners (counties, child welfare, probation officers, etc.) on addressing unique needs of children and youth.

6.2.8.1.10 Identifying a staff person to serve as the primary contact for the Wraparound Program within the region.

6.2.8.1.11 Assuring that the Wraparound Program delivers quality care that is consistent with Wraparound fidelity, this includes ensuring:

6.2.8.1.11.1 The ratio of Wraparound Program enrolled families to Wraparound care coordinator does not exceed 10:1, irrespective of whether the Wraparound care coordinators are employees of the Contractor or a Subcontractor.

6.2.8.1.11.2 Parent/caregiver peer support providers are trained, receive supervision, and do not have caseloads that exceed twenty (20) families.

6.2.8.1.12 Participating in community-based efforts to build the statewide System of Care.

6.2.8.1.13 Performing continuous quality improvement activities.

6.2.8.2 Wraparound Program Quarterly Report

6.2.8.2.1 The Contractor shall report to the Department every three (3) months the following information:

6.2.8.2.1.1 Total number of Wraparound Program enrollees for each month in the reporting period.

6.2.8.2.1.2 Ratio of Wraparound Program enrollees to Wraparound Facilitators

6.2.8.2.1.3 Ratio of Wraparound Program enrollees to parent/caregiver peers

6.2.9 DELIVERABLES

6.2.9.1 DELIVERABLE: Wraparound Program Enrollment List

6.2.9.1.1 DUE: Monthly, by the last day of the month.

6.2.9.2 DELIVERABLE: Wraparound Program Quarterly Report

6.2.9.2.1 DUE: Quarterly, on the last business day of July, October, January, and April.

6.3 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) GENERAL REQUIREMENTS

6.3.1 The Contractor shall manage the Colorado Pre-Admission Screen and Resident Review in accordance with state and federal statutes, rules and regulations for individuals who have or are suspected of having a mental illness or intellectual and/or developmental disability. State statutes include Section 27-1-201 *et seq.*, C.R.S., as amended and Section 27-10-101 *et seq.*, C.R.S., as amended.

6.3.2 The Contractors shall meet the three goals of PASRR: identify individuals with mental illness or intellectual and/or developmental disability, or both; ensure individuals are placed appropriately, whether in the community or in a nursing facility; and ensure that individuals receive the services required for their diagnosis in whatever setting they reside.

6.3.3 The Contractor shall use an existing information management system to manage and coordinate PASRR activities.

6.3.4 The Contractor shall attend all required PASRR training.

6.3.5 PASRR consists of these elements:

6.3.5.1 Pre-Admission Screen (PAS) Level I is a preliminary screen completed by staff from nursing facilities, Single Entry Point Agencies (SEPs) or hospital discharge planners (referring agencies) to indicate the possible presence of mental illness or intellectual and/or developmental disability for an individual seeking nursing facility admission.

6.3.5.2 PAS Level II is an in-depth evaluation completed by a trained assessor to confirm the presence of mental illness or intellectual and/or developmental disability, determine the appropriate living situation, and identify any specialized services are needed.

6.3.5.3 Resident Review is conducted whenever there is a change in the Member's condition that may affect their mental illness or intellectual and/or developmental disability status.

6.3.6 **Review PAS Level I Assessments**

6.3.6.1 The Contractor shall review PAS Level I assessments completed by referring agencies and submitted into the PASRR information management system. On average, the Department's contractor reviews approximately 17,000 PAS Level 1 assessments throughout the state.

6.3.6.1.1 The Contractor shall determine if a PAS Level II Assessment is required or if the Member may be admitted to a nursing facility without the Level II assessment.

6.3.6.1.2 The Contractors shall exempt the Member from a PAS Level II Assessment if the Member meets any of the following criteria:

6.3.6.1.2.1 Member has a terminal illness.

6.3.6.1.2.2 Member is placed provisionally in the facility due to an emergency placement or a placement from out-of-state.

6.3.6.1.2.3 Member is receiving respite care through the Program of All-Inclusive Care for the Elderly.

6.3.6.1.2.4 Nursing facility is for convalescent care. If a Member remains after the convalescent period, the Contractor shall ensure that the referring agency request a Resident Review or initiate a PAS Level II Assessment.

6.3.6.1.3 The Contractor shall review supporting documentation, such as the Uniform Long-Term Care 100.2 form, hospital discharge requests and medical records. If necessary, the Contractor shall consult with the referring agency, the Member's family, the Member's physician and others knowledgeable of the Member's current status.

6.3.6.1.4 For Members moving from out-of-state, the Contractor shall obtain information regarding the current placement, the reason for relocation to Colorado, any suspected mental illness or intellectual and/or developmental disability diagnoses, any current or past treatment or services and supports the person is receiving, any psychotropic medications, and the Member's psychiatric stability.

6.3.6.2 The Contractor shall complete the PAS Level I review, update the system with the results, and notify the referring agency of the results within six (6) business hours of receiving the PAS Level I Assessment. If the assessment is for a provisional emergency admission, the Contractor shall complete the review and notify the referring agency within six (6) hours, including on weekends and holidays.

6.3.6.3 The Contractor shall train referring agencies on how to submit a PAS Level I assessment to the information management system.

6.3.6.4 If a Member is unwilling to be admitted to a nursing facility or if a facility plans to place the Member in a secure unit, the Contractor shall ensure that the Member's guardian, medical power of attorney, medical proxy or other legal authority signs the Member into the nursing facility. If no legal authority is in place, the Contractor shall work with the facility to determine legal authority designation.

6.3.7 Conduct PAS Level II Assessment

6.3.7.1 The Contractor shall ensure that a trained Level II assessor completes a PAS Level II Assessment for any Member who needs it. The trained assessor may be an employee or a Subcontractor. The Contractor shall ensure that all assessors have clinical supervision.

6.3.7.1.1 The Contractor or its designee shall conduct a comprehensive desk review and ensure the accuracy of all assessment documents and confirm that a functional assessment for LTSS has been completed.

6.3.7.1.2 The Contractor or its designee shall conduct a face-to-face visit with the Member seeking admission to a nursing facility.

6.3.7.1.3 The Contractor or its designee shall arrange for a Developmental Disability Determination prior to scheduling the PAS Level II Assessment for Members who may have an intellectual and/or developmental disability but with no prior history of a determination.

6.3.7.1.4 The Contractor or its designee shall assess community-based alternatives for Members considering admission to a nursing facility.

6.3.7.1.5 The Contractor or its designee shall request additional information, when needed, from the State Mental Health Authority or the State Intellectual Disability Authority.

6.3.7.2 The Contractor shall complete and submit the Level II Assessment within nine (9) calendar days from the date of referral.

6.3.7.3 The Contractor shall request through the information management system that the State Mental Health Authority or State Intellectual Disability Authority review the Level II Assessment, and obtain a determination letter from the appropriate authority regarding the recommendation for placement and the need for specialized services.

6.3.7.4 If the Member requires specialized services, the Contractor shall ensure that the Member has a Case Management Agency. If the Member does not have a case manager, the Contractor shall assist the Member, family or guardian with selecting a Case Management Agency to arrange for specialized services.

6.3.7.5 The Contractor shall communicate the results of the Level II Assessment to the referring agency and nursing facility. For Members in need of specialized services, the Contractor shall also communicate the results of the assessment to the Case Management Agency.

6.3.7.6 On average, the Department's contractor performs approximately 2,200 Level II assessments annually throughout the state.

6.3.8 Coordinate Care Planning

6.3.8.1 The Contractor shall ensure that the nursing facility and, if applicable, the Case Management Agency and mental health center collaborate to create a Pre-Admission Care Plan. The Pre-Admission Care Plan includes what specialized services, if any, are to be provided by mental health or intellectual and/or developmental disability service providers, and which services are to be provided by the nursing facility.

6.3.8.2 The Contractor shall obtain approval for the Pre-Admission Care Plan from the State Mental Health Authority or the State Intellectual Disability Authority. The Contractor shall coordinate with the nursing facility to submit a revised plan if these authorities require it.

6.3.8.3 The Contractor shall ensure that the Pre-Admission Care Plan includes the plans, if required, for continuity of care.

6.3.9 Ensure Continuity of Care

6.3.9.1 The Contractor shall ensure continuity of care planning for Members receiving mental health or intellectual and/or developmental disability services, or for Members transferring from one RAE to another.

6.3.9.2 The Contractor shall notify the provider and other appropriate parties at the mental health center, Case Management Agency and intellectual disability service provider of the continuity of care plan. The Contractor shall:

6.3.9.2.1 Ensure that all necessary parties have been notified of the Member's transfer.

6.3.9.2.2 Review the continuity of care with the State Mental Health Authority or the State Intellectual Disability Authority, and communicate any revisions to the plan.

6.3.9.2.3 Include the final continuity of care plan in the completed Level II Assessment.

6.3.10 Ensure Resident Review for Status Change

6.3.10.1 The Contractor shall ensure that the nursing facility conducts a Level I update resident review for any Member residing in a nursing facility who experiences any the following changes:

6.3.10.1.1 Significant change in status affecting the Member's mental illness or intellectual and/or developmental disability status, including new or worsened serious symptoms

6.3.10.1.2 New diagnosis of mental illness or intellectual and/or developmental disability

6.3.10.1.3 Significant change in condition based on the Minimum Data Set (MDS) Assessment completed by nursing facilities

6.3.10.1.4 Expiration of a time limited approval, such as a provisional placement or convalescent care stay

6.3.10.2 The Contractor shall implement established protocols for accepting and responding to Level I updates from nursing facilities.

6.3.10.3 The Contractor shall review the Level I update to determine if a PAS Level II assessment is necessary. The Contractor shall complete the review and notify the nursing facility within three (3) business days of receiving the Level I update.

6.3.10.4 The Contractor shall train nursing facilities about the process for completing and submitting a Level I update resident review.

6.3.11 Oversee Quality and Compliance

6.3.11.1 The Contractor shall review quality of all PASRR reviews to assure that referring agencies are complying with the PASRR program.

6.3.11.2 The Contractor shall investigate noncompliance concerns to determine whether further investigation or action is warranted. As part of the investigation, the Contractor shall:

6.3.11.2.1 Implement a process for identifying a provider's noncompliance with the PASRR program.

6.3.11.2.2 Notify the provider of the noncompliance issue.

6.3.11.2.3 Report issues of noncompliance to the Department.

6.3.11.2.4 Review findings with the State Mental Health Authority and the State Intellectual Disability Authority.

6.3.11.2.5 Work with the Department to develop a corrective action plan for any compliance issues.

6.3.11.2.6 Provide education and technical assistance to the referring agency to address compliance issue.

6.3.11.2.7 Provide updates to the Department of the status of the corrective action plan.

6.3.11.2.8 Notify the referring agency when it has met the terms and conditions of the corrective action plan.

6.3.11.3 The Contractor shall maintain records of noncompliance information and enter non-compliance issues as they are identified in the information management system.

6.3.11.4 The Contractor shall track the location and outcome of the Members who had a PAS Level II Assessment.

6.4 BROKERING OF CASE MANAGEMENT AGENCIES

6.4.1 The Contractor shall serve as a broker to connect Members applying for or receiving Medicaid Long-Term Services and Supports (LTSS) to a Case Management Agency (CMA), an organization that works with the Member to develop an individualized service plan, arrange for appropriate services, choose providers, and monitor the health, safety, and welfare of Members and the implementation of the services. In FY 2015–16, 37,185 clients were enrolled in HCBS waivers and approximately 6,500 individuals became newly enrolled in HCBS waivers annually.

6.4.2 Provide Person-Centered Counseling for Choosing a CMA

6.4.2.1 The Contractor shall provide Members with open and informed choice among CMAs by functioning as a neutral party to connect Members with a CMA that addresses their needs and preferences.

6.4.2.1.1 The Contractor shall explain the choice process, including the Member's right to choose a CMA at any time, and the Contractor's role as an unbiased broker to Members.

6.4.2.1.2 If a Member has a preferred CMA, the Contractor shall honor that Member's choice so long as the CMA is not also providing direct services and can provide conflict-free case management.

6.4.2.1.3 If a Member does not have a preferred CMA, the Contractor shall review the options with the Member.

6.4.2.1.4 If a Member would like to meet with one or more CMAs before making a choice, the Contractor shall assist the Member or the Member's designated representative in setting up interviews.

6.4.2.2 The Contractor shall document all brokering activities within the Department-specified case management software. The Contractor shall include in its documentation that the Member was offered a choice of CMA, and which CMA the Member chose.

6.4.2.3 The Contractor shall provide disability competency training for its staff so they are able to knowledgeably and respectfully serve a range of Members with different needs.

6.4.2.4 The Contractor shall establish protocols for transferring case management brokering responsibilities to a new RAE when a Member moves to another region where the Member's current CMA does not provide case management.

6.4.2.5 The Contractor shall identify and contact Members who are receiving case management and HCBS direct services from the same agency, and help them choose a new CMA in accordance with the Department's conflict-free case management implementation plan.

6.4.3 Refer Members to a CMA

6.4.3.1 The Contractor shall implement the Department's referral protocols with each CMA in its region. Referral protocols shall address, at a minimum:

6.4.3.1.1 Information the CMA requires for a referral

6.4.3.1.2 Business process for transmitting the referral

6.4.3.1.3 Process for transitioning Members who choose a new CMA that better meets their needs

6.4.3.2 The Contractor shall provide to the Member, in writing, the contact information for the CMA to which the Member is referred, as well as the Member's right to choose a different CMA.

6.4.3.3 The Contractor shall follow up within two (2) business days of making a referral to ensure that the CMA has received the referral and is connecting with the Member.

6.4.3.4 The Contractor shall ensure that the agency providing case management services for a Member does not also provide HCBS direct services to that Member. Providing both case management and direct services is a conflict of interest that violates federal HCBS regulations and state statute.

6.4.3.5 The Contractor shall send a letter to the Member six (6) months after referring the Member to a CMA, to follow up on satisfaction with CMA service, provide an updated CMA list, and re-state the Member's right to choose and switch to a different CMA.

6.4.4 Maintain an Adequate Network of CMAs

6.4.4.1 The Contractor shall ensure that there is adequate choice of CMAs within the region. Network adequacy is defined as the choice of at least two (2) CMAs in rural areas and at least three (3) CMAs in urban areas.

6.4.4.2 The Contractor shall maintain a list of available CMAs in the region. The list shall include:

6.4.4.2.1 Each CMA in the region

6.4.4.2.2 A summary of the qualifications and expertise of each CMA

6.4.4.2.3 Other services each CMA provides that may conflict with unbiased case management for a Member

6.4.5 Align Activities with State Systems

6.4.5.1 The Contractor shall align its activities with the Department's implementation of No Wrong Door, which improves communication among LTSS entry point agencies to ensure Members receive timely and consistent information, and creates common entry points, where Members connect to Home and Community Based Services regardless of age, pay source or disability.

6.4.5.2 The Contractor shall monitor the Department's transition to conflict-free case management and adjust its activities to support the transition during each phase of implementation.

SECTION 7.0 COMPENSATION

7.1 SUMMARY OF COMPENSATION TO THE CONTRACTOR

7.1.1 Compensation to the Contractor shall consist of the following:

7.1.1.1 An administrative per-member per-month (PMPM) payment for each active Member enrolled in the Contractor's plan on the first day of the month.

7.1.1.2 A monthly capitation payment for each active Member enrolled in the Contractor's Capitated Behavioral Health Benefit on the first day of the month.

7.1.1.3 Quarterly and annual PMPM incentive payments based on the Contractor's performance on defined Key Performance Indicators.

7.1.1.4 Annual behavioral health incentive payment based on Contractor's performance on defined behavioral health metrics.

7.2 ADMINISTRATIVE PER-MEMBER PER-MONTH PAYMENT

7.2.1 The Department shall pay the Contractor a per-member per-month (PMPM) payment between $10.50 and $11.50 for each active Member enrolled in the Contractor's plan on the first day of the month.

7.2.2 The Department shall remit all PMPM payments through the Colorado interChange (MMIS).

7.2.3 The Department shall calculate the number of active Members enrolled in the Contractor's plan based on the number of enrollments in the Colorado interChange in the Contractor's plan.

7.2.4 The Department shall remit all PMPM payments to the Contractor within the month for which the PMPM payment applies.

7.2.4.1 In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, the Department shall compensate the Contractor for that Member retroactively.

7.3 MONTHLY PAYMENT FOR CAPITATED BEHAVIORAL HEALTH BENEFIT

7.3.1 The Department shall pay the Contractor the appropriate Monthly Capitation Rate as specified in Appendix V, Draft Behavioral health Capitation Rates, for each Member by the fifteenth (15th) Business Day of the month.

7.3.2 The Department shall calculate the number of active Members enrolled in the Contractor's plan based on the number of enrollments in the Colorado interChange in the Contractor's plan.

7.3.3 The Department shall remit payment through an electronic transfer of funds to the bank account designated by the Contractor. The Department shall provide the Contractor with a monthly payment report through the Colorado interChange.

7.3.3.1 The Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

7.3.4 The Department will remove the amount submitted in the annual Third Party Recovery Report, described in Section 5.12.11, from the calculation of the Monthly Capitation Rates. The Department will not seek recovery of reimbursement from the Contractor.

7.3.5 When a material underpayment error in the amount of the Monthly Capitation Rate has been made due to an error by the Department, the Department shall remit to the Contractor the amount necessary to correct the error within ten (10) Business Days of notification of the error by the Contractor to the Department.

7.3.6 Where membership is disputed between two Contractors, the Department shall be the final arbiter of membership and shall recoup any Monthly Capitation Rate amounts paid in error.

7.3.7 The Monthly Capitation Rate shall be considered payment in full for all covered services set forth in Section 5.12.5.

7.3.8 In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Section 5.12.5 and any other provision of the Contract, Section 5.12.5 shall prevail over other provisions of this Contract.

7.3.9 Health Insurance Providers Fee Rate Settlement

7.3.9.1 The Contractor and the Department shall engage in Health Insurance Providers Fee Rate Settlements based upon the Health Insurance Fee report provided by the Contractor to the Department each October.

7.3.9.1.1 During the rate-setting cycle, the Department will calculate a prospective rate to account for the health insurance provider fee. This rate will be withheld from the Contractor's payment.

7.3.9.1.2 Upon receipt of the Health Insurance Providers Fee Report, the Department will calculate the actual rate to account for the health insurance provider fee. The Department will issue a notification letter by July 31 each year with the amount to be remitted to the Contractor.

7.4 PAY FOR PERFORMANCE

7.4.1 Key Performance Indicators

7.4.1.1 The Department shall pay the Contractor for performance on KPIs on a quarterly or annual basis depending on how often the metric is calculated.

7.4.1.2 The Department shall remit all incentive payments through the Colorado interChange.

7.4.1.3 The Department shall make payments to the Contractor for meeting either Level 1 or Level 2 performance goals for each of the KPIs.

7.4.1.3.1 The Department shall pay sixty-six percent (66%) of the full payment available for a KPI measure if the Contractor meets the Level 1 target.

7.4.1.3.2 The Department shall pay one hundred percent (100%) of the full payment available for a KPI measure if the Contractor meets the Level 2 target.

7.4.1.3.3 Full payment for each KPI is $0.44 PMPM.

7.4.1.4 The Department shall remit all payments on KPIs to the Contractor quarterly within one hundred and twenty (120) days from the last day of the quarter in which these payments were earned. The Department will calculate the KPIs separately for each month in a quarter, and the Contractor may receive different amounts for each month within a quarter based on the specific performance targets the Contractor was able to meet during each specified month.

7.4.2 Behavioral Health Incentive Payment

7.4.2.1 The Department shall pay the Contractor annually for performance on the Behavioral Health Incentive metrics upon execution of an option letter.

7.4.2.2 The Department shall distribute monies for the Behavioral Health Incentive once annually within one hundred and twenty (120) days of completion of the State Fiscal Year.

7.5 PAYMENT FOR ADDITIONAL STATEMENT OF WORK ACTIVITIES

7.5.1 The Department shall pay the Contractor for an additional Statement of Work activity upon execution of an option letter.

7.5.2 Wraparound Program

7.5.2.1 The Department shall pay the Contractor an enhanced administrative PMPM payment between $800–$1,000 for each child and youth who is actively engaged in the Contractor's Wraparound Program by the fifteenth (15th) Business Day of the month.

7.5.2.2 The Department shall remit all PMPM payments to the Contractor within the month for which the PMPM payment applies.

7.5.2.2.1 In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, the Department shall compensate the Contractor for that Member retroactively.

7.5.3 PASRR Administration

7.5.3.1 The Department shall pay the Contractor a maximum of $XXXX annually for administering PASSR based on the proportion of the Contractor's enrolled Members who may have an intellectual and/or developmental disability or mental illness diagnosis, who have been admitted into a nursing facility in the previous State Fiscal Year.

7.5.3.2 The Department shall adjust the amount the Contractor is paid from year to year based on PASRR trends and data from the previous State Fiscal Year.

7.5.3.3 The Department shall pay the Contractor one-twelfth (1/12) of the annual contract maximum on a monthly basis following the Contractor's submission of weekly PASRR activity reports and a monthly invoice.

7.5.3.4 The combined total of invoices from all RAE Contractors cannot exceed the amount of funds available to the Department for PASRR administration.

7.5.4 PAS Level II and Status Change Assessments

7.5.4.1 The Department shall pay the Contractor the following unit rates per Assessment performed:

7.5.4.1.1	Pre-Admission Level II Assessment	$510.00
7.5.4.1.2	Pre-Admission Partial Level II Assessment	$200.00
7.5.4.1.3	Status Change Level II Assessment	$510.00
7.5.4.1.4	Status Change Partial Level II Assessment	$200.00

7.5.4.1.5	Categorical Determination	$65.00
7.5.4.1.6	Status Change over the Phone	$65.00

7.5.4.2 Payment pursuant to this contract for PAS Level II Assessments, including those completed as result of a status change, will be made as earned, in whole or in part, from available federal and state funds encumbered in an amount not to exceed the amount of funds available for each State Fiscal Year this contract is in effect.

7.5.4.2.1 The funds that are available for each State Fiscal Year shall be used to pay multiple RAE Contractors to complete PASRR Assessments. The liability of the state, at any time, for such payments shall be limited to the unexpended amount remaining of such funds allocated to PASRR Assessments.

7.5.4.3 Partial Assessments apply to those instances where a full Level II Assessment is not required because the Member has a prior Level II Assessment that needs to be updated, or a status change of the Member only requires that the current Level II Assessment be updated.

7.5.5 Case Management Broker Services

7.5.5.1 The Department shall pay the Contractor a maximum of $XXXX annually for case management brokering.

7.5.5.2 The Department shall pay the Contractor for case management brokering based on the proportion of the Contractor's enrolled Members who were determined eligible for LTSS services in the previous State Fiscal Year.

7.5.5.3 The Department shall adjust the amount the Contractor is paid from year to year based on trends in LTSS enrollment and data of the previous State Fiscal Year.

7.5.5.4 The Department shall pay the Contractor one-twelfth (1/12) of the annual contract maximum on a monthly basis following the Contractor's submission of weekly case management brokering activity reports and a monthly invoice.

7.5.5.5 The combined total of invoices from all RAE Contractors cannot exceed the amount of funds available to the Department for case management brokering.

7.6 PAYMENT CALCULATION DISPUTES

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

7.7 RECOUPMENTS

7.7.1.1 The Department shall recoup monthly payment rate amounts paid to the Contractor in error. Error may be either human or machine error on the part of the Department, the Contractor or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, change in RAE enrollment due to a Member choosing a new PCMP, or situations where the Member cannot use the Contractor's facilities.

7.7.1.2 The Contractor shall refund to the Department any overpayments due the Department within thirty (30) days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) days, the Department shall deduct the overpayments from the next payment to the Contractor.

7.7.1.3 The Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) days of termination.

7.7.1.4 Payments made by the Department to the Contractor due to the Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

7.7.1.5 Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any Monthly Payment Rate amounts paid in error.

7.7.1.6 The Contractor's obligation to refund all calculated rebates continues subsequent to the termination of the Contract.

SECTION 8.0 EVALUATION METHODOLOGY

8.1 EVALUATION PROCESS

8.1.1 The evaluation of proposals will result in a recommendation for award of the Contract. The award will be made to the Offeror whose proposal, conforming to the solicitation, will be most advantageous to the State of Colorado, price and other factors considered.

8.1.2 The Department will conduct a comprehensive, thorough, complete and impartial evaluation of each proposal received.

8.1.3 The Department will select a vendor in compliance with 24-103-203(7), C.R.S., which states, "The award shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the state, taking into consideration the price and evaluation factors set forth in the request for proposal."

8.1.4 The Department encourages proposals from Service-Disabled Veteran Owned Small Businesses. Each Offeror that is a Service-Disabled Veteran Owned Small Businesses should submit verification that it is incorporated or organized in Colorado or maintains a place of business or has an office in Colorado and is officially registered and verified as a Service-Disabled Veteran Owned Small Business by the Center for Veteran Enterprise within the U.S. Department of Veterans Affairs. (www.vip.vetbiz.gov)

8.2 EVALUATION COMMITTEE

8.2.1 An Evaluation Committee will be established utilizing measures to ensure the integrity of the evaluation process. These measures include the following:

8.2.1.1 Selecting committee members who do not have a conflict of interest regarding this solicitation.

8.2.1.2 Facilitating the independent review of proposals.

8.2.1.3 Requiring the evaluation of the proposals to be based strictly on the content of the proposals.

8.2.1.4 Ensuring the fair and impartial treatment of all Offerors.

8.2.2 The objective of the Evaluation Committee is to conduct reviews of the proposals that have been submitted, to hold frank and detailed discussions among themselves, and to recommend an Offeror for award.

8.2.3 The Evaluation Committee will evaluate proposals to determine if each Offeror met all mandatory qualification requirements. The mandatory qualification requirements are scored on a Met/Not Met basis and only those proposals found by the Evaluation Committee to meet all mandatory requirements can be considered for a Contract resulting from this solicitation.

8.2.4 Proposals will be evaluated by the Evaluation Committee using the evaluation criteria identified by the Department and posted in the final RFP. The evaluators will consider whether all critical elements described in the solicitation have been addressed, the capabilities of the Offeror, the quality of the approach and/or solution proposed, the price and any other aspect determined relevant by the Department.

8.2.5 The Evaluation Committee will determine which proposal is the most advantageous to the State of Colorado by performing a value analysis.

8.2.6 The Evaluation Committee will perform a value analysis by comparing the technical differences among proposals and whether these differences justify paying the cost differential provided in each Offeror's proposal.

8.2.6.1 A Service-Disabled Veteran Owned Small Business may be given up to a five percent (5%) preference in the sole discretion of the Department.

8.2.7 The Evaluation Committee will have discretion in determining the manner and extent to which it will utilize technical and cost evaluation results. For example, the Evaluation Committee may award to an Offeror with higher costs if the Committee determines that the benefits of the technical differences for that Offeror's proposal outweigh the proposal's cost difference.

8.2.8 Based on the Evaluation Committee's value analysis, the Committee will determine which Offeror is most advantageous to the State. The Evaluation Committee will explain its value analysis and the determination in a written document.

8.2.9 The Evaluation Committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers. The Evaluation Committee may adjust its scoring based on the results of such activities. However, proposals may be reviewed and determinations made without such activities. Offerors should be aware that the opportunity for further explanation might not exist; therefore, it is important that all proposal submissions are complete.

8.3 COMPLIANCE

8.3.1 It is the Offeror's responsibility to ensure that Offeror's proposal is complete in accordance with the direction provided within all solicitation documents. Failure of an Offeror to provide any required information and/or failure to follow the response format set forth in Appendix E, Administrative Information, may result in the disqualification of that Offeror's proposal.