Contract Routing Number 15-68385

STATE OF COLORADO
Department of Health Care Policy and Financing
Contract with
Colorado Health Partnerships, LLC
for
Behavioral Health Services Program

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1. PARTIES

This Contract (hereinafter called "Contract") is entered into by and between Colorado Health Partnerships, LLC, 7150 Campus Drive, Suite 300, Colorado Springs, CO 80920 (hereinafter called "Contractor"), and the STATE OF COLORADO acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called the "State" or "Department"). Contractor and the State hereby agree to the following terms and conditions.

2. EFFECTIVE DATE AND NOTICE OF NONLIABILITY

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

3. RECITALS

A. Authority, Appropriation, and Approval

Authority to enter into this Contract exists in 25.5-1-101 et. seq. and funds have been budgeted, appropriated and otherwise made available and a sufficient unencumbered balance thereof remains available for payment. Required approvals, clearance and coordination have been accomplished from and with appropriate agencies.

B. Consideration

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

C. Purpose

The purpose of this Contract is for the administration of the Community Behavioral Health Services Program (the Program) that provides comprehensive mental health and substance use disorder services to Medicaid clients in Colorado.. Contractor's offer, submitted in response to Request for Proposal (RFP) Number HCPFRFPSM14BEHAVHEALTH was selected by the State.

D. References

All references in this Contract to sections (whether spelled out or using the § symbol), subsections, exhibits or other attachments, are references to sections, subsections, exhibits or other attachments contained herein or incorporated as a part hereof, unless otherwise noted.

4. DEFINITIONS

The following terms as used herein shall be construed and interpreted as follows:

A. "Closeout Period" means the period of time defined in Exhibit A, Statement of Work.

B. "Contract" means this Contract, its terms and conditions, attached addenda, exhibits, documents incorporated by reference under the terms of this Contract, and any future modifying agreements, exhibits, attachments or references incorporated herein pursuant to Colorado State law, Fiscal Rules, and State Controller Policies.

C. Exhibits and other Attachments. The following documents are attached hereto and incorporated by reference herein:

HIPAA Business Associate Addendum
Exhibit A, Statement of Work
Exhibit C, Sample Option Letter
Exhibit D, Covered Behavioral Health Diagnoses
Exhibit E, Covered Behavioral Health Procedure Codes
Exhibit F, Combined Core Competencies
Exhibit G, Performance Measures
Exhibit H, Procedure Codes Exempt from CCAR
Exhibit I, Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI)
Exhibit J, Developmental Disability (DD)
Exhibit K, Wrap Around Services

D. "Goods" means tangible material acquired, produced, or delivered by Contractor either separately or in conjunction with the Services Contractor renders hereunder.

E. "Party" means the State or Contractor and Parties means both the State and Contractor.

F. "Review" means examining Contractor's Work to ensure that it is adequate, accurate, correct, and in accordance with the standards described in this Contract.

G. "Services" means the required services to be performed by Contractor pursuant to this Contract.

H. "State Fiscal Year" or "SFY" means the twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year.

I. "Subcontractor" means third-parties, if any, engaged by Contractor to aid in performance of its obligations.

J. "Work" means the tasks and activities Contractor is required to perform to fulfill its obligations under this Contract, including the performance of the Services and delivery of the Goods.

K. "Work Product" means the tangible or intangible results of Contractor's Work, including, but not limited to, software, research, reports, studies, data, photographs, negatives or other finished or unfinished documents, drawings, models, surveys, maps, materials, or work product of any type, including drafts.

Any terms used herein which are defined in Exhibit A, Statement of Work shall be construed and interpreted as defined therein.

5. TERM

A. Initial Term

The Parties' respective performances under this Contract shall commence on the later of either the Effective Date or July 1, 2014. This Contract shall expire on June 30, 2015, unless sooner terminated or further extended as specified elsewhere herein.

B. Two Month Extension

The State, at its sole discretion, upon written notice to Contractor as provided in **§16**, may unilaterally extend the term of this Contract for a period not to exceed two months if the Parties desire to continue the services and a replacement Contract has not been fully executed by the expiration of any initial term or renewal term. The provisions of this Contract in effect when such notice is given, including, but not limited to, prices, rates and delivery requirements, shall remain in effect during the two month extension. The two (2) month extension shall immediately terminate when and if a replacement contract is approved and signed by the Colorado State Controller or an authorized designee, or at the end of two (2) months, whichever is earlier.

C. Option to Extend

The State may require continued performance for a period of one (1) year or less at the same rates and same terms specified in the Contract. If the State exercises this option, it shall provide written notice to Contractor at least thirty (30) days prior to the end of the current Contract term in form substantially equivalent to **Exhibit C**. If exercised, the provisions of the Option Letter shall become part of and be incorporated into this Contract. In no event shall the total duration of this Contract, from the Operational Start Date until termination and including the exercise of any options under this clause, exceed five (5) years, unless the State receives approval from the State Purchasing Director or delegate.

6. STATEMENT OF WORK

A. Completion

Contractor shall complete the Work and its other obligations as described in this Contract on or before the end of the term of this Contract. The State shall not be liable to compensate Contractor for any Work performed prior to the Effective Date or after the expiration or termination of this Contract.

B. Goods and Services

Contractor shall procure Goods and Services necessary to complete the Work. Such procurement shall not increase the maximum amount payable hereunder by the State.

C. Independent Contractor

All persons employed by Contractor or Subcontractors to perform Work under this Contract shall be Contractor's or Subcontractors' employee(s) for all purposes hereunder and shall not be employees of the State for any purpose as a result of this Contract.

7. PAYMENTS TO CONTRACTOR

The State shall, in accordance with the provisions of this **§7** and **Exhibit A**, Statement of Work, pay Contractor in the amounts and using the methods set forth below:

A. Payment

In accordance with and subject to Section 5.0 of **Exhibit A**, the State shall pay Contractor for all earned Per Member Per Month payments and incentive payments.

B. Interest

The State shall not pay interest on any amounts due to Contractor hereunder.

C. Available Funds-Contingency-Termination

The State is prohibited by law from making commitments beyond the term of the State's current fiscal year. Therefore, Contractor's compensation beyond the State's current fiscal year is contingent upon the continuing availability of State appropriations as provided in the Colorado Special Provisions, set forth below. If federal funds are used to fund this Contract, in whole or in part, the State's performance hereunder is contingent upon the continuing availability of such funds. Payments pursuant to this Contract shall be made only from available funds and the State's liability for such payments shall be limited to the amount remaining of such available funds. If State or federal funds are not appropriated, or otherwise become unavailable to fund this Contract, the State may terminate this Contract immediately, in whole or in part, without further liability notwithstanding any notice and cure period in **§14.**B.

D. Erroneous Payments

At the State's sole discretion, payments made to Contractor in error for any reason, including, but not limited to, overpayments or improper payments, may be recovered from Contractor by deduction from subsequent payments under this Contract or other contracts, grants or agreements between the State and Contractor or by other appropriate methods and collected as a debt due to the State. Such funds shall not be paid to any party other than the State.

E. Closeout Payments

Notwithstanding anything to the contrary in this Contract, all payments for the final month of the Contract shall be paid to the Contractor no sooner than ten (10) days after the Department has determined that the Contractor has completed all of the requirements of the Closeout Period.

F. Option to Increase or Decrease Statewide Quantity of Service

The Department may increase or decrease the statewide quantity of services described in the Contract based upon the rates established in the Contract. If the Department exercises the option, it will provide written notice to Contractor in a form substantially equivalent to **Exhibit C**. Delivery/performance of services shall continue at the same rates and terms. If exercised, the provisions of the Option Letter shall become part of and be incorporated into the original Contract.

8. REPORTING NOTIFICATION

Reports required under this Contract shall be in accordance with the procedures and in such form as prescribed by the State and as described in **Exhibit A**.

A. Litigation Reporting

Within ten (10) days after being served with any pleading in a legal action filed with a court or administrative agency, related to this Contract or which may affect Contractor's ability to perform its obligations hereunder, Contractor shall notify the State of such action and deliver copies of such pleadings to the State's principal representative as identified herein. If the State's principal representative is not then serving, such notice and copies shall be delivered to the Executive Director of the Department.

B. Noncompliance

Contractor's failure to provide reports and notify the State in a timely manner in accordance with this **§8** may result in the delay of payment of funds and/or termination as provided under this Contract.

9. CONTRACTOR RECORDS

A. Maintenance

Contractor shall make, keep, maintain, and allow inspection and monitoring by the State of a complete file of all records, documents, communications, notes, and other written materials, electronic media files and electronic communications, pertaining in any manner to the Work or the delivery of Services or Goods hereunder. Contractor shall maintain such records until the last to occur of: **(i)** a period of six (6) years after the date this Contract expires or is sooner terminated, or **(ii)** a period of six (6) years after final payment is made hereunder, or **(iii)** a period of six (6) years after the resolution of any pending Contract matters, or **(iv)** if an audit is occurring, or Contractor has received notice that an audit is pending, until such audit has been completed and its findings have been resolved (collectively, the "Record Retention Period"). All such records, documents, communications and other materials shall be the property of the State, and shall be maintained by the Contractor in a central location and the Contractor shall be custodian on behalf of the State.

B. Inspection

Contractor shall permit the State, the federal government and any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and/or transcribe Contractor's records related to this Contract during the Record Retention Period, to assure compliance with the terms hereof or to evaluate performance hereunder. The State reserves the right to inspect the Work at all reasonable times and places during the term of this Contract, including any extensions or renewals. If the Work fails to conform with the requirements of this Contract, the State may require Contractor promptly to bring the Work into conformity with Contract requirements, at Contractor's sole expense. If the Work cannot be brought into conformance by re-performance or other corrective measures, the State may require Contractor to take necessary action to ensure that future performance conforms to Contract requirements and exercise the remedies available under this Contract, at law or in equity, in lieu of or in conjunction with such corrective measures.

C. Monitoring

Contractor shall permit the State, the federal government and any other duly authorized agent of a government agency, in their sole discretion, to monitor all activities conducted by Contractor pursuant to the terms of this Contract using any reasonable procedure, including, but not limited to: internal evaluation procedures, examination of program data, special analyses, on-site checking, formal audit examinations, or any other procedure. All monitoring controlled by the State shall be performed in a manner that shall not unduly interfere with Contractor's performance hereunder.

D. Final Audit Report

If an audit is performed on Contractor's records for any fiscal year covering a portion of the term of this Contract, Contractor shall submit a copy of the final audit report to the State or its principal representative at the address specified herein.

10. CONFIDENTIAL INFORMATION

Contractor shall comply with the provisions of this **§10** if it becomes privy to confidential information in connection with its performance hereunder. Confidential information includes, but is not necessarily limited to, any state records, personnel records, and information concerning individuals. Such information shall not include information required to be disclosed pursuant to the Colorado Open Records Act, CRS §24-72-101, et seq.

A. Confidentiality

Contractor shall keep all State records and information confidential at all times and comply with all laws and regulations concerning confidentiality of information. Any request or demand by a third party for State records and information in the possession of Contractor shall be immediately forwarded to the State's principal representative.

B. Health Insurance Portability & Accountability Act of 1996 ("HIPAA")

i. Federal Law and Regulations

Pursuant to federal law and regulations governing the privacy of certain health information, the Contractor, to the extent applicable, shall comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d – 1320d-8 ("HIPAA") and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164 (the "Privacy Rule") and other applicable laws, as amended.

ii. Business Associate Contract

Federal law and regulations governing the privacy of certain health information requires a "Business Associate Contract" between the State and the Contractor, 45 C.F.R. Section 164.504(e). Attached and incorporated herein by reference and agreed to by the parties is a HIPAA Business Associate Addendum ("Addendum") for HIPAA compliance. Terms of the Addendum shall be considered binding upon execution of this Contract and shall remain in effect during the term of the Contract including any extensions.

iii. Confidentiality of Records

Whether or not an Addendum is attached to this Contract, the Contractor shall protect the confidentiality of all records and other materials containing personally identifying information that are maintained in accordance with the Contract and comply with HIPAA rules and regulations. Except as provided by law, no information in possession of the Contractor about any individual constituent shall be disclosed in a form including identifying information without the prior written consent of the person in interest, a minor's parent, or guardian. The Contractor shall have written policies governing access to, duplication and dissemination of, all such information. The Contractor shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the federal Health Insurance Portability and Accountability Act of 1996.

C. Notification

Contractor shall notify its agents, employees, Subcontractors and assigns who may come into contact with State records or other confidential information that each is subject to the confidentiality requirements set forth herein, and shall provide each with a written explanation of such requirements before permitting them to access such records and information.

D. Use, Security, and Retention

Confidential information of any kind shall not be distributed or sold to any third party or used by Contractor or its agents in any way, except as authorized by this Contract or approved in writing by the State. Contractor shall provide and maintain a secure environment that ensures confidentiality of all State records and other confidential information wherever located. Confidential information shall not be retained in any files or otherwise by Contractor or its agents, except as permitted in this Contract or approved in writing by the State.

E. Disclosure-Liability

Disclosure of State records or other confidential information by Contractor for any reason may be cause for legal action by third parties against Contractor, the State or their respective agents. Contractor shall indemnify, save, and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees and related costs, incurred as a result of any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees pursuant to this **§10**.

11. CONFLICTS OF INTEREST

A. Contractor shall not engage in any business or personal activities or practices or maintain any relationships which conflict in any way with the full performance of Contractor's obligations hereunder. Contractor acknowledges that with respect to this Contract, even the appearance of a conflict of interest is harmful to the State's interests. Absent the State's prior written approval, Contractor shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Contractor's obligations to the State hereunder. If a conflict or appearance exists, or if Contractor is uncertain whether a conflict or the appearance of a conflict of interest exists, Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the apparent conflict constitutes a breach of this Contract.

B. The Contractor (and Subcontractors or subgrantees permitted under the terms of this Contract) shall maintain a written code of standards governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Contractor, Subcontractor, or subgrantee shall participate in the selection, or in the award or administration of a contract or subcontract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

i. The employee, officer or agent;
ii. Any member of the employee's immediate family;
iii. The employee's partner; or
iv. An organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Contractor's, Subcontractor's, or subgrantee's officers, employees, or agents

will neither solicit nor accept gratuities, favors, or anything of monetary value from Contractors, potential Contractors, or parties to subagreements.

12. REPRESENTATIONS AND WARRANTIES

Contractor makes the following specific representations and warranties, each of which was relied on by the State in entering into this Contract.

A. Standard and Manner of Performance

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

B. Legal Authority – Contractor Signatory

Contractor warrants that it possesses the legal authority to enter into this Contract and that it has taken all actions required by its procedures, and bylaws, and/or applicable laws to exercise that authority, and to lawfully authorize its undersigned signatory to execute this Contract, or any part thereof, and to bind Contractor to its terms. If requested by the State, Contractor shall provide the State with proof of Contractor's authority to enter into this Contract within five (5) days of receiving such request.

C. Licenses, Permits, Etc.

Contractor represents and warrants that as of the Effective Date it has, and that at all times during the term hereof it shall have and maintain, at its sole expense, all licenses, certifications, approvals, insurance, permits and other authorizations required by law to perform its obligations hereunder. Contractor warrants that it shall maintain all necessary licenses, certifications, approvals, insurance, permits, and other authorizations required to properly perform this Contract, without reimbursement by the State or other adjustment in the Contract. Additionally, all employees, agents, and Subcontractors of Contractor performing Services under this Contract shall hold all required licenses or certifications, if any, to perform their responsibilities. Contractor, if a foreign corporation or other foreign entity transacting business in the State of Colorado, further warrants that it currently has obtained and shall maintain any applicable certificate of authority to transact business in the State of Colorado and has designated a registered agent in Colorado to accept service of process. Any revocation, withdrawal or non-renewal of licenses, certifications, approvals, insurance, permits or any such similar requirements necessary for Contractor to properly perform the terms of this Contract is a material breach by Contractor and constitutes grounds for termination of this Contract.

13. INSURANCE

Contractor and its Subcontractors shall obtain and maintain insurance as specified in this section at all times during the term of this Contract. All policies evidencing the insurance coverage required hereunder shall be issued by insurance companies satisfactory to Contractor and the State.

A. Contractor

i. Public Entities

If Contractor is a "public entity" within the meaning of the Colorado Governmental Immunity Act, CRS §24-10-101, et seq., as amended (the "GIA"), then Contractor shall maintain at all times during the term of this Contract such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the GIA. Contractor shall show proof of such insurance satisfactory to the State, if requested by the State. Contractor shall require each contract with a Subcontractor that is a public entity, to include the insurance requirements necessary to meet such Subcontractor's liabilities under the GIA.

ii. Non-Public Entities

If Contractor is not a "public entity" within the meaning of the GIA, Contractor shall obtain and maintain during the term of this Contract insurance coverage and policies meeting the requirements set forth in **§13.B**.

B. Contractors – Subcontractors

Contractor shall require each contract with Subcontractors other than those that are public entities, providing Goods or Services in connection with this Contract, to include insurance requirements substantially similar to the following:

i. Worker's Compensation

Worker's Compensation Insurance as required by State statute, and Employer's Liability Insurance covering all of Contractor's or Subcontractor's employees acting within the course and scope of their employment.

ii. General Liability

Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows:

a. $1,000,000 each occurrence;
b. $1,000,000 general aggregate;
c. $1,000,000 products and completed operations aggregate; and
d. $50,000 any one fire.

If any aggregate limit is reduced below $1,000,000 because of claims made or paid, Subcontractor shall immediately obtain additional insurance to restore the full aggregate limit and furnish to Contractor a certificate or other document satisfactory to Contractor showing compliance with this provision.

iii. Protected Health Information Insurance

Liability insurance covering all loss of Protected Health Information data and claims based upon alleged violations of privacy rights through improper use or disclosure of Protected Health Information with minimum limits as follows:

a. $1,000,000 each occurrence; and
b. $2,000,000 general aggregate.

iv. Automobile Liability

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

v. Professional Liability Insurance

Professional Liability Insurance covering any damages caused by an error, omission or any negligent acts with minimum limits as follows:

a. $1,000,000 each occurrence; and
b. $1,000,000 general aggregate.

vi. Additional Insured

The State shall be named as additional insured on all Commercial General Liability and protected health information insurance policies (leases and construction contracts require additional insured coverage for completed operations on endorsements CG 2010 11/85, CG 2037, or equivalent) required of Contractor and any Subcontractors hereunder.

vii. Primacy of Coverage

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

viii. Cancellation

The above insurance policies shall include provisions preventing cancellation or non-renewal without at least 30 days prior notice to Contractor and Contractor shall forward such notice to the State in accordance with **§16** (Notices and Representatives) within seven days of Contractor's receipt of such notice.

ix. Subrogation Waiver

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

C. Certificates

Contractor and all Subcontractors shall provide certificates showing insurance coverage required hereunder to the State within seven (7) business days of the

Effective Date of this Contract. No later than fifteen (15) days prior to the expiration date of any such coverage, Contractor and each Subcontractor shall deliver to the State or Contractor certificates of insurance evidencing renewals thereof. In addition, upon request by the State at any other time during the term of this Contract or any subcontract, Contractor and each Subcontractor shall, within ten (10) days of such request, supply to the State evidence satisfactory to the State of compliance with the provisions of this **§13**.

14. BREACH

A. Defined

In addition to any breaches specified in other sections of this Contract, the failure of the Contractor to perform any of its material obligations hereunder in whole or in part or in a timely or satisfactory manner, constitutes a breach. The institution of proceedings under any bankruptcy, insolvency, reorganization or similar law, by or against Contractor, or the appointment of a receiver or similar officer for Contractor or any of its property, which is not vacated or fully stayed within twenty (20) days after the institution or occurrence thereof, shall also constitute a breach.

B. Notice and Cure Period

In the event of a breach, the State shall notify the Contractor of such in writing in the manner provided in **§16**. If such breach is not cured within ten (10) days of receipt of written notice, the State may exercise any of the remedies set forth in **§15**. Notwithstanding anything to the contrary herein, the State, in its sole discretion, need not provide advance notice or a cure period and may immediately terminate this Contract in whole or in part if reasonably necessary to preserve public safety or to prevent immediate public crisis.

15. REMEDIES

A. Termination for Cause and/or Breach

If Contractor is in breach under any provision of this Contract, the State shall have all of the remedies listed in this **§15** in addition to all other remedies set forth in other sections of this Contract, and without limiting its remedies otherwise available at law or equity, following the notice and cure period set forth in **§14.B**. Remedies are cumulative and the State may exercise any or all of the remedies available to it, in its sole discretion, concurrently or consecutively. The State may terminate this entire Contract or any part of this Contract. Exercise by the State of this right shall not be a breach of its obligations hereunder.

i. Obligations and Rights

To the extent specified in any termination notice, Contractor shall not incur further obligations or render further performance hereunder past the effective date of such notice, and shall terminate outstanding orders and subcontracts with third parties. However, Contractor shall complete and deliver to the State all Work, Services and Goods not cancelled by the termination notice. Contractor shall continue performance of this Contract

up to the effective date of the termination. To the extent the Contract is not terminated, if any, Contractor shall continue performance until the expiration of this Contract. At the sole discretion of the State, Contractor shall assign to the State all of Contractor's right, title, and interest under such terminated orders or subcontracts. Upon termination, Contractor shall take timely, reasonable and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest. All materials owned by the State in the possession of Contractor shall be immediately returned to the State. All Work Product, at the option of the State, shall be delivered by Contractor to the State and shall become the State's property. The Contractor shall be obligated to return any payment advanced under the provisions of this Contract.

ii. Payments

The State shall reimburse Contractor only for accepted performance up to the effective date of the termination. If, after termination by the State, it is determined that Contractor was not in breach or that Contractor's action or inaction was excusable, such termination shall be treated as a termination in the public interest and the rights and obligations of the Parties shall be the same as if this Contract had been terminated in the public interest, as described herein.

iii. Damages and Withholding

Notwithstanding any other remedial action by the State, Contractor shall remain liable to the State for any damages sustained by the State by virtue of any breach under this Contract by Contractor and the State may withhold any payment to Contractor for the purpose of mitigating the State's damages, until such time as the exact amount of damages due to the State from Contractor is determined. The State may withhold any amount that may be due Contractor as the State deems necessary to protect the State against loss, including loss as a result of outstanding liens, claims of former lien holders, or for the excess costs incurred in procuring similar goods or services. Contractor shall be liable for excess costs incurred by the State in procuring from third parties replacement Work, Services or substitute Goods as cover.

B. Early Termination in the Public Interest

The State is entering into this Contract for the purpose of carrying out the public policy of the State of Colorado, as determined by its Governor, General Assembly, and/or courts. If this Contract ceases to further the public policy of the State, the State, in its sole discretion, may terminate this Contract, in whole or in part. Exercise by the State of this right shall not constitute a breach of the State's obligations hereunder. This subsection shall not apply to a termination of this Contract by the State for cause or breach by Contractor, which shall be governed by **§15.A** or as otherwise specifically provided for herein.

i. Method and Content

The State shall notify Contractor of such termination in accordance with **§16.** The notice shall specify the effective date of the termination, which shall be at least twenty (20) days, and whether it affects all or a portion of this Contract.

ii. Obligations and Rights

Upon receipt of a termination notice, Contractor shall be subject to and comply with the same obligations and rights set forth in **§15.A.i**.

iii. Payments

If this Contract is terminated by the State pursuant to this **§15.B**, Contractor shall be paid an amount which bears the same ratio to the total reimbursement under this Contract as Contractor's obligations that were satisfactorily performed bear to the total obligations set forth in this Contract, less payments previously made. Additionally, if this Contract is less than 60% completed upon the effective date of such termination, the State may reimburse Contractor for a portion of actual out-of-pocket expenses (not otherwise reimbursed under this Contract) incurred by Contractor prior to the effective date of the termination in the public interest which are directly attributable to the uncompleted portion of Contractor's obligations hereunder; provided that the sum of any and all reimbursement shall not exceed the maximum amount payable to Contractor hereunder.

C. Additional Remedies

The State, in its sole discretion, may exercise one or more of the following remedies in addition to other remedies available to it:

i. Suspend Performance

Suspend Contractor's performance with respect to all or any portion of this Contract pending necessary corrective action as specified by the State without entitling Contractor to an adjustment in price/cost or performance schedule. Contractor shall promptly cease performance of such portions of the contract.

ii. Withhold Payment

Withhold payment to Contractor until Contractor's performance or corrections in Contractor's performance are satisfactorily made and completed.

iii. Deny/Reduce Payment

Deny payment for those obligations not performed in conformance with Contract requirements, that due to Contractor's actions or inactions, cannot be performed or, if performed, would be of no value to the State; provided, that any denial or reduction of payment shall be reasonably related to the value to the State of the obligations not performed.

iv. Removal

Notwithstanding any other provision herein, the State may demand immediate removal of any of Contractor's employees, agents, or Subcontractors whom the State deems incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued relation to this Contract is deemed to be contrary to the public interest or the State's best interest.

v. Intellectual Property

If Contractor infringes on a patent, copyright, trademark, trade secret or other intellectual property right while performing its obligations under this Contract, Contractor shall, at the State's option:

a. Obtain for the State or Contractor the right to use such products and services;
b. Replace any Goods, Services, or other product involved with non-infringing products or modify them so that they become non-infringing; or,
c. If neither of the foregoing alternatives are reasonably available, remove any infringing Goods, Services, or products and refund the price paid therefore to the State.

16. NOTICES AND REPRESENTATIVES

Each individual identified below is the principal representative of the designating Party. All notices required to be given hereunder shall be hand delivered with receipt required or sent by certified or registered mail to such Party's principal representative at the address set forth below. In addition to, but not in lieu of, a hard-copy notice, notice also may be sent by e-mail to the e-mail addresses, if any, set forth below. Either Party may from time to time designate by written notice substitute addresses or persons to whom such notices shall be sent. Unless otherwise provided herein, all notices shall be effective upon receipt.

For the State:
Matthew Ullrich and Nikki Lemmon
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203
matthew.ullrich@state.co.us and nikki.lemmon@state.co.us

For the Contractor:
Arnold Salazar, Chief Executive Officer
Colorado Health Partnerships, LLC
7150 Campus Drive
Suite 300
Colorado Springs, CO 80920
arnolds@CHNPartners.com

17. RIGHTS IN DATA, DOCUMENTS, AND COMPUTER SOFTWARE

Any software, research, reports, studies, data, photographs, negatives or other documents, drawings, models, materials, or Work Product of any type, including drafts, specifically and solely prepared by Contractor in and for the performance of its obligations under this Contract shall be the exclusive property of the State, and all Work Product shall be delivered to the State by Contractor upon completion or termination hereof. The State's exclusive rights in such Work Product shall include, but not be limited to, the right to copy, publish, display, transfer, and prepare derivative works. Contractor shall not use, willingly allow, cause or permit such Work Product to be used for any purpose other than the performance of Contractor's obligations hereunder without the prior written consent of the State.

18. GOVERNMENTAL IMMUNITY

Liability for claims for injuries to persons or property arising from the negligence of the State of Colorado, its departments, institutions, agencies, boards, officials, and employees is controlled and limited by the provisions of the Colorado Governmental Immunity Act, CRS §24-10-101, *et seq.*, and the risk management statutes, CRS §24-30-1501, *et seq.*, as now or hereafter amended.

19. GENERAL PROVISIONS

A. Assignment and Subcontracts

Contractor's rights and obligations hereunder are personal and may not be transferred, assigned or subcontracted without the prior, written consent of the State. Any attempt at assignment, transfer or subcontracting without such consent shall be void. All assignments, subcontracts, or Subcontractors approved by the Contractor or the State are subject to all of the provisions hereof. Contractor shall be solely responsible for all of the Work performed under this Contract, regardless of whether Subcontractors are used and for all aspects of subcontracting arrangements and performance. Copies of any and all subcontracts entered into by Contractor to perform its obligations hereunder shall be in writing and submitted to the State upon request. Any and all subcontracts entered into by Contractor related to its performance hereunder shall require the Subcontractor to perform in accordance with the terms and conditions of this Contract and to comply with all applicable federal and state laws. Any and all subcontracts shall include a provision that such subcontracts are governed by the laws of the State of Colorado.

B. Binding Effect

Except as otherwise provided in **§19.A**, all provisions herein contained, including the benefits and burdens, shall extend to and be binding upon the Parties' respective heirs, legal representatives, successors, and assigns.

C. Captions

The captions and headings in this Contract are for convenience of reference only, and shall not be used to interpret, define, or limit its provisions.

D. Counterparts

This Contract may be executed in multiple identical original counterparts, all of which shall constitute one agreement.

E. Entire Understanding

This Contract represents the complete integration of all understandings between the Parties regarding the Work and all prior representations and understandings, oral or written, related to the Work are merged herein. Prior or contemporaneous additions, deletions, or other changes hereto shall not have any force or effect whatsoever, unless embodied herein.

F. Indemnification

Contractor shall indemnify, save, and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees and related costs, incurred as a result of any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees pursuant to the terms of this Contract; however, the provisions hereof shall not be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 *et seq.*, or the Federal Tort Claims Act, 28 U.S.C. 2671 et seq., as applicable, as now or hereafter amended.

G. Jurisdiction and Venue

All suits or actions related to this Contract shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver.

H. Modification

i. By the Parties

Except as specifically provided in this Contract, modifications of this Contract shall not be effective unless agreed to in writing by the Parties in an amendment to this Contract, properly executed and approved in accordance with applicable Colorado State law and State Fiscal Rules. Modifications permitted under this Contract, other than contract amendments, shall conform to the policies of the Office of the State Controller, including, but not limited to, the policy entitled MODIFICATIONS OF CONTRACTS - TOOLS AND FORMS.

ii. By Operation of Law

This Contract is subject to such modifications as may be required by changes in Federal or Colorado State law, or their implementing regulations. Any such required modification automatically shall be incorporated into and be part of this Contract on the effective date of such change, as if fully set forth herein.

I. Order of Precedence

The provisions of this Contract shall govern the relationship of the State and Contractor. In the event of conflicts or inconsistencies between this Contract and its exhibits and attachments, including, but not limited to, those provided by Contractor, such conflicts or inconsistencies shall be resolved by reference to the documents in the following order of priority:

i. Colorado Special Provisions
ii. HIPAA Business Associate Addendum
iii. The provisions of the main body of this Contract
iv. Exhibit A, Statement of Work
v. Exhibit C, Sample Option Letter
vi. Exhibit D, Covered Behavioral Health Diagnoses
vii. Exhibit E, Covered Behavioral Health Procedure Codes
viii. Exhibit F, Combined Core Competencies
ix. Exhibit G, Performance Measures
x. Exhibit H, Procedure Codes Exempt from CCAR
xi. Exhibit I, Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI)
xii. Exhibit J, Developmental Disability (DD)
xiii. Exhibit K, Wrap Around Services

J. Severability

Provided this Contract can be executed and performance of the obligations of the Parties accomplished within its intent, the provisions hereof are severable and any provision that is declared invalid or becomes inoperable for any reason shall not affect the validity of any other provision hereof.

K. Survival of Certain Contract Terms

Notwithstanding anything herein to the contrary, provisions of this Contract requiring continued performance, compliance, or effect after termination hereof, shall survive such termination and shall be enforceable by the State if Contractor fails to perform or comply as required.

L. Taxes

The State is exempt from all federal excise taxes under IRC Chapter 32 (No. 84-730123K) and from all State and local government sales and use taxes under CRS §§39-26-101 and 201, *et seq*. Such exemptions apply when materials are purchased or services are rendered to benefit the State; provided, however, that certain political subdivisions (e.g., City of Denver) may require payment of sales or use taxes even though the product or service is provided to the State. Contractor shall be solely liable for paying such taxes as the State is prohibited from paying or reimbursing Contractor for such taxes.

M. Third Party Beneficiaries

Enforcement of this Contract and all rights and obligations hereunder are reserved solely to the Parties. Any services or benefits which third parties receive as a result

of this Contract are incidental to the Contract, and do not create any rights for such third parties.

N. Waiver

Waiver of any breach under a term, provision, or requirement of this Contract, or any right or remedy hereunder, whether explicitly or by lack of enforcement, shall not be construed or deemed as a waiver of any subsequent breach of such term, provision or requirement, or of any other term, provision, or requirement.

O. CORA Disclosure

To the extent not prohibited by federal law, this Contract and the performance measures and standards under CRS §24-103.5-101, if any, are subject to public release through the Colorado Open Records Act, CRS §24-72-101, et seq.

20. ADDITIONAL GENERAL PROVISIONS

A. Compliance with Applicable Law

The Contractor shall at all times during the execution of this Contract strictly adhere to, and comply with, all applicable federal and state laws, and their implementing regulations, as they currently exist and may hereafter be amended, which are incorporated herein by this reference as terms and conditions of this Contract. The Contractor shall also require compliance with these statutes and regulations in subcontracts and subgrants permitted under this contract. The federal laws and regulations include:

Age Discrimination Act of 1975, as amended	42 U.S.C. 6101, et seq.
Age Discrimination in Employment Act of 1967	29 U.S.C. 621-634
Americans with Disabilities Act of 1990 (ADA)	42 U.S.C. 12101, et seq.
Clean Air Act	42 U.S.C. 7401, et seq.
Equal Employment Opportunity	E.O. 11246, as amended by E.O. 11375, amending E.O. 11246 and as supplemented by 41 C.F.R. Part 60
Equal Pay Act of 1963	29 U.S.C. 206(d)
Federal Water Pollution Control Act, as amended	33 U.S.C. 1251, et seq.
Immigration Reform and Control Act of 1986	8 U.S.C. 1324b
Section 504 of the Rehabilitation Act of 1973, as amended	29 U.S.C. 794
Title VI of the Civil Rights Act of 1964, as amended	42 U.S.C. 2000d, et seq.

Title VII of the Civil Rights Act of 1964	42 U.S.C. 2000e
Title IX of the Education Amendments of 1972, as amended	20 U.S.C. 1681

State laws include:

Civil Rights Division	Section 24-34-301, CRS, *et seq*.

The Contractor also shall comply with any and all laws and regulations prohibiting discrimination in the specific program(s) which is/are the subject of this Contract. In consideration of and for the purpose of obtaining any and all federal and/or state financial assistance, the Contractor makes the following assurances, upon which the State relies.

i. The Contractor will not discriminate against any person on the basis of race, color, national origin, age, sex, religion or handicap, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, in performance of Work under this Contract.

ii. At all times during the performance of this Contract, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied benefits of the service, programs, or activities performed by the Contractor, or be subjected to any discrimination by the Contractor.

The Contractor shall take all necessary affirmative steps, as required by 45 C.F.R. 92.36(e), Colorado Executive Order and Procurement Rules, to assure that small and minority businesses and women's business enterprises are used, when possible, as sources of supplies, equipment, construction, and services purchased under this Contract.

B. Federal Audit Provisions

Office of Management and Budget (OMB) Circular No. A-133, Audits of States, Local Governments, and Non-Profit Organizations, defines audit requirements under the Single Audit Act of 1996 (Public Law 104-156). All state and local governments and non-profit organizations expending $500,000.00 or more from all sources (direct or from pass-through entities) are required to comply with the provisions of Circular No. A-133. The Circular also requires pass-through entities to monitor the activities of subrecipients and ensure that subrecipients meet the audit requirements. To identify its pass-through responsibilities, the State of Colorado requires all subrecipients to notify the State when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.00.

C. Debarment and Suspension

i. If this is a covered transaction or the Contract amount exceeds $100,000.00, the Contractor certifies to the best of its knowledge and belief that it and its principals and Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency.

ii. This certification is a material representation of fact upon which reliance was placed when the State determined to enter into this transaction. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available at law or by contract, the State may terminate this Contract for default.

iii. The Contractor shall provide immediate written notice to the State if it has been debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency.

iv. The terms “covered transaction,” “debarment,” “suspension,” “ineligible,” “lower tier covered transaction,” “principal,” and “voluntarily excluded,” as used in this paragraph, have the meanings set out in 2 C.F.R. Parts 180 and 376.

v. The Contractor agrees that it will include this certification in all lower tier covered transactions and subcontracts that exceed $100,000.00.

D. Force Majeure

Neither the Contractor nor the State shall be liable to the other for any delay in, or failure of performance of, any covenant or promise contained in this Contract, nor shall any delay or failure constitute default or give rise to any liability for damages if, and only to the extent that, such delay or failure is caused by "force majeure." As used in this Contract, “force majeure” means acts of God; acts of the public enemy; acts of the state and any governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather.

E. Disputes

Except as herein specifically provided otherwise, disputes concerning the performance of this Contract which cannot be resolved by the designated Contract representatives shall be referred in writing to a senior departmental management staff designated by the State and a senior manager designated by the Contractor. Failing resolution at that level, disputes shall be presented in writing to the Executive Director of the State and the Contractor’s Chief Executive Officer for resolution. This process is not intended to supersede any other process for the resolution of controversies provided by law.

F. Lobbying

Contractor certifies, to the best of his or her knowledge and belief, that:

i. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative Contract, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative Contract.

ii. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative Contract, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

iii. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative Contracts) and that all subrecipients shall certify and disclose accordingly.

iv. This certification is a material representation of fact upon which reliance was placed when the transaction was made or entered into. Submission of the certification is a requisite for making or entering into transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

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21. COLORADO SPECIAL PROVISIONS

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

A. **CONTROLLER'S APPROVAL**. **CRS §24-30-202(1)**. This contract shall not be valid until it has been approved by the Colorado State Controller or designee.

B. **FUND AVAILABILITY**. **CRS §24-30-202(5.5)**. Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

C. **GOVERNMENTAL IMMUNITY**. No term or condition of this contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 et seq., or the Federal Tort Claims Act, 28 U.S.C. §§1346(b) and 2671 et seq., as applicable now or hereafter amended.

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

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

F. **CHOICE OF LAW**. Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this contract. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. Any provision incorporated herein by reference which purports to negate this or any other Special Provision in whole or in part shall not be valid or enforceable or available in any action at law, whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision shall not invalidate the remainder of this contract, to the extent capable of execution.

G. **BINDING ARBITRATION PROHIBITED.** The State of Colorado does not agree to binding arbitration by any extra-judicial body or person. Any provision to

the contrary in this contact or incorporated herein by reference shall be null and void.

H. **SOFTWARE PIRACY PROHIBITION. Governor's Executive Order D 002 00**. State or other public funds payable under this contract shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Contractor hereby certifies and warrants that, during the term of this contract and any extensions, Contractor has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Contractor is in violation of this provision, the State may exercise any remedy available at law or in equity or under this contract, including, without limitation, immediate termination of this contract and any remedy consistent with federal copyright **laws** or applicable licensing restrictions.

I. **EMPLOYEE FINANCIAL INTEREST/CONFLICT OF INTEREST**. **CRS §§24-18-201 and 24-50-507**. The signatories aver that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this contract. Contractor has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Contractor's services and Contractor shall not employ any person having such known interests.

J. **VENDOR OFFSET**. **CRS §§24-30-202 (1) and 24-30-202.4**. [***Not Applicable to intergovernmental agreements***] Subject to CRS §24-30-202.4 (3.5), the State Controller may withhold payment under the State's vendor offset intercept system for debts owed to State agencies for: **(a)** unpaid child support debts or child support arrearages; **(b)** unpaid balances of tax, accrued interest, or other charges specified in CRS §39-21-101, et seq.; **(c)** unpaid loans due to the Student Loan Division of the Department of Higher Education; **(d)** amounts required to be paid to the Unemployment Compensation Fund; and **(e)** other unpaid debts owing to the State as a result of final agency determination or judicial action.

K. **PUBLIC CONTRACTS FOR SERVICES. CRS §8-17.5-101.** ***[Not Applicable to agreements relating to the offer, issuance, or sale of securities, investment advisory services or fund management services, sponsored projects, intergovernmental agreements, or information technology services or products and services]*** Contractor certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this contract and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this contract, through participation in the E-Verify Program or the Department program established pursuant to CRS §8-17.5-102(5)(c), Contractor shall not knowingly employ or contract with an illegal alien to perform work under this contract or enter into a contract with a subcontractor that fails to certify to Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this contract. Contractor (a) shall not use E-Verify Program or Department program procedures to undertake pre-employment screening of job applicants while this contract is being performed, (b) shall notify the subcontractor and the contracting

State agency within three days if Contractor has actual knowledge that a subcontractor is employing or contracting with an illegal alien for work under this contract, (c) shall terminate the subcontract if a subcontractor does not stop employing or contracting with the illegal alien within three days of receiving the notice, and (d) shall comply with reasonable requests made in the course of an investigation, undertaken pursuant to CRS §8-17.5-102(5), by the Colorado Department of Labor and Employment. If Contractor participates in the Department program, Contractor shall deliver to the contracting State agency, Institution of Higher Education or political subdivision a written, notarized affirmation, affirming that Contractor has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Contractor fails to comply with any requirement of this provision or CRS §8-17.5-101 et seq., the contracting State agency, institution of higher education or political subdivision may terminate this contract for breach and, if so terminated, Contractor shall be liable for damages.

L. **PUBLIC CONTRACTS WITH NATURAL PERSONS. CRS §24-76.5-101.** Contractor, if a natural person eighteen (18) years of age or older, hereby swears and affirms under penalty of perjury that he or she **(a)** is a citizen or otherwise lawfully present in the United States pursuant to federal law, **(b)** shall comply with the provisions of CRS §24-76.5-101 et seq., and **(c)** has produced one form of identification required by CRS §24-76.5-103 prior to the effective date of this contract.

SIGNATURE PAGE

THE PARTIES HERETO HAVE EXECUTED THIS CONTRACT

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

CONTRACTOR
Colorado Health Partnerships, LLC

_____
***Signature**

Date:_____

By:_____
Name of Authorized Individual

Title:_____
Official Title of Authorized Individual

STATE OF COLORADO
John W. Hickenlooper, Governor
Department of Health Care Policy and Financing

_____
Susan E. Birch, MBA, BSN, RN
Executive Director

Signatory avers to the State Controller or delegate that Contractor has not begun performance or that a Statutory Violation waiver has been requested under Fiscal Rules

Date:_____

LEGAL REVIEW
John W. Suthers, Attorney General

By:_____
Signature - Assistant Attorney General

Date:_____

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

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

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

By:_____
Department of Health Care Policy and Financing

Date:_____

HIPAA BUSINESS ASSOCIATE ADDENDUM

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

RECITALS

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

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

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

The parties agree as follows:

1. Definitions.

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

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

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

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

2. Obligations of Associate.

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

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

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

safeguards as needed to ensure continued provision of reasonable and appropriate protection of Protected Information.

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

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

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

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

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

responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Section 2(b) of this Addendum.

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

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

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

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

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

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

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

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

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

3. Obligations of CE.

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

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

4. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by Associate of any provision of this Addendum, as determined by CE, shall

constitute a material breach of this Contract and shall provide grounds for immediate termination of this Contract by CE pursuant to the provisions of the Contract covering termination for cause, if any. If the Contract contains no express provisions regarding termination for cause, the following terms and conditions shall apply:

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

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

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

c. Effect of Termination.

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

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

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

6. No Waiver of Immunity. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Colorado Governmental Immunity Act, CRS 24-10-101 *et seq*. or the

Federal Tort Claims Act, 28 U.S.C. 2671 *et seq*. as applicable, as now in effect or hereafter amended.

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

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

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

10. Amendment.

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

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

11. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any Subcontractors, employees or agents assisting Associate in the performance of its obligations under the Contract, available to CE, at no cost to CE, up to a maximum of thirty (30) hours, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against CE, its directors, officers or employees based upon a claimed violation of the HIPAA Rules or other laws relating to security and privacy or PHI, in which the actions of Associate are at issue, except where Associate or its Subcontractor, employee or agent is a named adverse party.

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

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

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

ATTACHMENT A

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

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

No Additional Permitted Uses.

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

No additional permitted disclosures.

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

Providers.

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

Upon receipt of PHI from the Department.

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

No additional restrictions on Use of Data.

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

No additional terms.

EXHIBIT A, STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY

1.1.1. Acronyms, abbreviations and other terminology are defined at their first occurrence in this Contract. The following list is provided to assist the reader in understanding acronyms, abbreviations and terminology used throughout this document.

1.1.1.1. Accountable Care Collaborative (ACC) - A program designed to affordably optimize client health, functioning and self-sufficiency. The primary goals of the ACC Program are to improve Medicaid client health outcomes and control costs. Regional Care Collaborative Organizations (RCCOs), a Statewide Data and Analytics Contractor (SDAC), and Primary Care Medical Providers (PCMPs) that will serve as Medical Homes work together in collaboration with ACC Program Members and other Medicaid providers to optimize the delivery of outcomes-based, cost-effective health care services.

1.1.1.2. Adults without Dependent Children (AwDC) - As used in 25.5-4-402.3 C.R.S. means a category of Medical Assistance for adults who are at least age 19 but less than 65 years without Medicaid eligible dependent children living in the client's household. SSI disability determination is not required for this population. AwDC enrollees are covered under a federal 1115 Demonstration Waiver.

1.1.1.3. Advanced Directive - A written instrument recognized under Section 15-14-505(2), C.R.S. relating to the provision of medical care when the individual is incapacitated.

1.1.1.4. Behavioral Health – Mental health and/or substance use disorders and includes diagnoses and services related to mental health and/or substance use disorders.

1.1.1.5. BHO – Behavioral Health Organization

1.1.1.6. Business Day - Any day in which the Department is open and conducting business, but shall not include weekend days or any day on which one of the Department's holidays are observed. The Department observes all holidays listed in C.R.S. §24-11-101(1).

1.1.1.7. 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.

1.1.1.8. CFR - The Code of Federal Regulations.

1.1.1.9. CHP+ - The Colorado Child Health Plan *Plus*.

1.1.1.10. Care Coordination - The process of identifying, screening and assessing Members' needs, identification of and referral to appropriate services and coordinating and monitoring an individualized treatment plan. This treatment plan shall also include a strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning and consent to the treatment.

1.1.1.11. Client - Any individual enrolled in the Colorado Medicaid program as determined by the Department.

1.1.1.12. Contractor's Service Area - The geographical area served by the Contractor under the Contract. The Contractor's Service Area shall include the SouthWest Region of Colorado as defined by the Department.

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

1.1.1.14. 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.

1.1.1.15. Early Periodic Screening, Diagnosis and Treatment (EPSDT) - A program that provides comprehensive health care to all Medicaid eligible children through periodic screenings, diagnostic and treatment services.

1.1.1.16. Effective Date - The effective date defined in the Contract.

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

1.1.1.17.1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy.

1.1.1.17.2. Serious impairment to bodily functions.

1.1.1.17.3. Serious dysfunction of any bodily organ or part.

1.1.1.18. Emergency Services – Covered inpatient and outpatient hospital services that are:

1.1.1.18.1. Furnished by a Provider that is qualified to administer these services under 42 CFR Section 438; and

1.1.1.18.2. Needed to evaluate or stabilize an Emergency Medical Condition.

1.1.1.19. Encounter Data – The electronic record of an occurrence of examination or treatment of a patient or other behavioral health services rendered by a medical practitioner or in a medical facility.

1.1.1.20. Enrollee – A Medicaid recipient who is currently enrolled in a managed care organization (MCO), prepaid inpatient hospital plan (PIHP), prepaid ambulatory

hospital plan (PAHP), or primary care case management (PCCM) in a given managed care program as defined at 42 CFR 438.10(a).

1.1.1.21. Essential Community Provider (ECP) – Are providers that historically serve medically needy or medically indigent patients 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 C.R.S. § 25.5-5-404.2.

1.1.1.22. Evidence-based practices – Programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results.

1.1.1.23. Federally Qualified Health Center – A provider defined at 10 C.C.R. 2505-10, Section 8.700.1.

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

1.1.1.25. Hospital Services - Those medically necessary Covered Services for patients that are generally and customarily provided by acute care and psychiatric Hospitals. Hospital Services shall also include services rendered in the emergency room and/or the outpatient department of any Hospital. Except for an Emergency Medical Condition or Written Referral, Hospital Services are Covered Services only when performed by Participating Providers.

1.1.1.26. Integration of Care - Coordinated and unified treatment of health concerns across the physical and behavioral health spectrum.

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

1.1.1.28. Marketing - Any communication, from the Contractor to a Medicaid eligible person who is not Enrolled with that Contractor, that can reasonably be interpreted as intended to influence the Medicaid eligible person to Enroll with that particular Contractor, or either to not Enroll in, or to disenroll from, another Contractor or managed care organization.

1.1.1.29. Marketing Materials – Materials that are produced in any medium, by or on behalf of a Contractor or can reasonably be interpreted as intended to market to potential Members.

1.1.1.30. Medically Necessary - Describes a service that, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care:

1.1.1.30.1. Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder;

1.1.1.30.2. Is clinically appropriate in terms of type, frequency, extent, site and duration;

1.1.1.30.3. Is furnished in the most appropriate and least restrictive setting where services can be safely provided; and

1.1.1.30.4. Cannot be omitted without adversely affecting the Member's behavioral health and/or physical health conditions associated with the Member's covered behavioral health diagnosis, or the quality of care rendered.

1.1.1.31. Medical Record - The collection of personal information, which relates an individual's physical or behavioral condition, medical history, or medical treatment, that is obtained from a single health care Provider, medical care institution, Member of the Contractor's plan, or the spouse, parent or legal guardian of a Member.

1.1.1.32. Member - Any Medicaid eligible Client that is enrolled in the Community Behavioral Health Services Program.

1.1.1.33. Monthly Capitation Rate – The capitated rate specified in Exhibit B, Rates, attached and incorporated herein by reference, payable for each Member under this Contract.

1.1.1.34. Non-State Plan Services – Refers to 1915(b)(3) services provided in the Community Behavioral Health Services Program.

1.1.1.35. Nursing Facility - An institution that meets state and federal requirements for participation as a Nursing Facility.

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

1.1.1.37. Operational Start Date - when the Department authorizes the Offeror to begin fulfilling its obligations under the Contract.

1.1.1.38. Other Personnel - Individuals and Subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Work outlined in this solicitation.

1.1.1.39. PHI - Protected Health Information.

1.1.1.40. Participating Provider - Any Physician, Hospital, or other healthcare professional or facility that has entered into a professional service agreement with the Contractor to provide clinical services to the Contractor's Members.

1.1.1.41. Physician - Any doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.

1.1.1.42. 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, under the circumstances described in 42 CFR Section 438.114(a), to improve or resolve the Member's condition.

1.1.1.43. Prepaid Inpatient Health Plan (PIHP) - A plan that meets the requirements of 42 CFR § 438.2.

1.1.1.44. Promising Practices – Practices that may have demonstrated efficacy through qualitative evaluation protocols but have not yet been supported by quantitative, peer-reviewed scientific publication.

1.1.1.45. Primary Care Medical Provider (PCMP) - A primary care provider who serves as a Medical Home for Members. PCMP practices may be Federally Qualified Health Centers, RHCs, clinics or other group practices that provide the majority of a

Member's comprehensive primary, preventive and sick care. Individual PCMPs can be physicians, advanced practice nurses, or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

1.1.1.46. Program - Community Behavioral Health Services Program that provides comprehensive behavioral health services to Medicaid members in Colorado.

1.1.1.47. Provider - A health care practitioner, institution, agency or supplier, that may or may not be a Participating Provider in the Contractor's plan, but which furnishes or arranges for health care services with an expectation of receiving payment.

1.1.1.48. Provider Network - A network of Participating Providers, established and maintained by Contractor, capable of serving the behavioral health needs of all Members in the Program.

1.1.1.49. Regional Care Collaborative Organization (RCCO) - One of seven (7) regional entities contracted with the Department to support the ACC Program by improving the health outcomes for Members and controlling the cost of care.

1.1.1.50. Statewide Data and Analytics Contractor (SDAC) - The entity with which the Department has contracted to provide data aggregation, analysis and distribution in support of the Accountable Care Collaborative program.

1.1.1.51. SFY - State Fiscal Year.

1.1.1.52. Start-Up Period - The period from the execution of the Contract, until the Operational Start Date.

1.1.1.53. Site Review – The visit of Department staff or its designees to the site or the administrative office(s) of a Participating Provider, the Contractor and its Participating Providers and/or Subcontractors.

1.1.1.54. Termination/Terminated - When used in the context of membership means action taken by the Department to disenroll a Member from the Community Behavioral Health Services Program operated by the Contractor.

1.1.1.55. Treatment Foster Care - A clinically effective alternative to residential treatment facilities that combines the treatment technologies typically associated with more restrictive settings with a nurturing and individualized family environment.

1.1.1.56. Urgent Medical Condition - A medical condition that has the potential to become an Emergency Medical Condition in the absence of treatment.

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

1.1.1.58. U.S.C. - The United States Code

1.1.1.59. Written Referral/Referral - Any form or written communication by the Contractor that authorizes specific behavioral health and/or Hospital Services. A Written

Referral shall be utilized for Covered Service(s) to be performed by Referral Providers.

SECTION 2.0 ENROLLMENT, POPULATIONS SERVED AND COVERED SERVICES

2.1. ENROLLMENT

2.1.1. Medicaid Clients residing in the Contractor's Service Area are enrolled into the Contractor's plan and are eligible to receive Medicaid mental health and substance use benefits unless exempt pursuant to 10 C.C.R. 2505-10, Section 8.212.

2.1.1.1. Enrollment into the Program occurs automatically each month and is effective on the day in which the individual becomes eligible for Medicaid. Members shall be automatically reenrolled when they lose and regain eligibility.

2.1.1.2. Members are enrolled to the date that Medicaid eligibility began and/or reenrolled retroactively to the date that eligibility was reinstated up to a maximum of three (3) months.

2.1.2. Capitation payments are made to BHOs for the established period of retroactive eligibility.

2.1.3. Disenrollment from the Program shall not be permitted except as provided in 10 C.C.R. 2505-10, Section 8.212.

2.1.4. The Health Insurance Portability and Accountability Act (HIPAA) 834 Benefit Enrollment and Maintenance transaction generated from the Medicaid Management Information System (MMIS) shall be utilized by the Contractor to verify Medicaid eligibility and enrollment in the Contractor's plan. The Colorado Medical Assistance Program Web Portal may also be used to verify Medicaid eligibility and enrollment in the Contractor's plan. The Department is the final arbiter for all discrepancies between the various systems utilized for verifying eligibility and enrollment.

2.1.5. The following individuals are not eligible for enrollment in the Program:

2.1.5.1. Qualified Medicare Beneficiary only (QMB-only).

2.1.5.2. Qualified Disabled and Working Individuals (QDWI).

2.1.5.3. Qualified Individuals 1 (QI 1).

2.1.5.4. Special Low Income Medicare Beneficiaries (SLMB).

2.1.5.5. Undocumented aliens.

2.1.5.6. Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE).

2.1.5.7. Individuals who are inpatients at the Colorado Mental Health Institute at Pueblo ("Institute") who are:

2.1.5.7.1. Found by a criminal court to be not guilty by reason of insanity ("NGRI").

2.1.5.7.2. Found by a criminal court to be incompetent to proceed (ITP).

2.1.5.7.3. Ordered by a criminal court to a State Institute for Mental Disease (IMD) for evaluation (e.g., competency to proceed, sanity, conditional release revocation, pre-sentencing).

2.1.5.8. Individuals between ages twenty-one (21) and sixty-four (64) who receive inpatient treatment at the Colorado Mental Health Institute in Pueblo, Colorado or the Colorado Mental Health Institute at Fort Logan.

2.1.5.9. Individuals who are NGRI and who are in the community on temporary physical removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Mental Health Services Program while they are on TPR. TPR individuals remain under the control and care of the Colorado Mental Health Institute at Pueblo.

2.1.5.10. Individuals residing in the state regional centers and associated satellite residences for more than ninety (90) days; Classes of individuals determined by the

Department to require exclusion from the Community Behavioral Health Services Program.

2.1.5.11. Individuals who receive an individual exemption as set forth at 10 C.C.R. 2505-10, Section 8.212.

2.1.5.12. All individuals while determined presumptively eligible for Medicaid.

2.1.5.13. Children/youth in the custody of the Colorado Department of Human Services Division of Child Welfare or Division of Youth Corrections who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF) as defined in C.R.S. § 25.5-4-103 or a Residential Child Care Facility (RCCF) as defined in C.R.S. § 26-6-102.

2.2. COVERED SERVICES

2.2.1. The Contractor shall provide or arrange for the provision of all medically necessary Covered Services, including services identified under the federal Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), 42 CFR Sections 441.50 to 441.62.

2.2.2. The Contractor is not expected to manage inpatient substance use disorder services. Funding for inpatient substance use disorder services shall not be included in the Contract.

2.2.3. The Contractor shall not be liable for any Covered Services provided prior to the date a Member is enrolled under this Contract or after the date of Disenrollment.

2.2.4. The Contractor shall manage the following Covered State Plan Services:

2.2.4.1. Inpatient Hospital

2.2.4.1.1. The Contractor's responsibility for all inpatient hospital services shall be based on the primary diagnosis that requires inpatient level of care and is being managed within the treatment plan of the Member.

2.2.4.1.1.1. The Contractor shall be 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).

2.2.4.1.1.2. The Contractor shall not be 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.

2.2.4.2. Outpatient services, including:

2.2.4.2.1. Psychiatrists.

2.2.4.2.2. Rehabilitative services.

2.2.4.2.3. Group behavioral health therapy.

2.2.4.2.4. Individual behavioral health therapy.

2.2.4.2.5. Individual brief behavioral health therapy.

2.2.4.2.6. Family behavioral health therapy.

2.2.4.2.7. Behavioral health assessment.

2.2.4.2.8. Medication management.

2.2.4.2.9. Outpatient day treatment.

2.2.4.3. Emergency services that are:

2.2.4.3.1. Furnished by a provider that is qualified to administer these services according to 42 CFR Section 438.

2.2.4.3.2. Needed to evaluate or stabilize an Emergency Medical Condition.

2.2.4.3.2.1. The Contractor shall not be responsible for outpatient emergency room services billed on a UB-04 for Members diagnosed with a primary substance use disorder.

2.2.4.3.2.2. The Contractor shall be responsible for practitioner emergency room claims billed on a CO-1500 for Members diagnosed with both substance use and/or mental health disorders.

2.2.4.4. Crisis services.

2.2.4.4.1. The Contractor shall be responsible for coverage and payment of Emergency Services and Post-Stabilization Care Services as specified in 42 CFR § 438.114(b) and 42 CFR § 422.113(c). The Contractor:

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

2.2.4.4.1.2. Shall not deny payment for treatment obtained under either of the following circumstances:

2.2.4.4.1.2.1. A Member had an Emergency Medical Condition in which the absence of immediate medical attention would not necessarily have had the outcomes specified in the definition of Emergency Medical Condition.

2.2.4.4.1.2.2. A representative of the Contractor instructs the Member to seek Emergency Services.

2.2.4.4.1.3. Shall not refuse to cover Emergency Services based on the emergency room Provider, Hospital or fiscal agent not notifying the Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.2.4.4.2. 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 to stabilize the Member.

2.2.4.4.3. The attending emergency Physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently

stabilized for transfer or discharge and that determination is binding on the Contractor for coverage and payment.

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

2.2.4.4.5. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's network that are not pre-

approved by the Contractor, but that are administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

2.2.4.4.5.1. The Contractor does not respond to a request for pre-approval within one (1) hour of receiving the request.

2.2.4.4.5.2. The Contractor cannot be contacted.

2.2.4.4.5.3. The Contractor and the treating Provider cannot reach an agreement concerning the Member's care and a plan Provider is not available for consultation. In this situation, the Contractor shall give the treating Provider the opportunity to consult with a plan Provider and the treating Provider may continue with care of the patient until a plan Provider is reached or one of the criteria in 42 CFR Section 422.113(c)(3) is met.

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

2.2.4.4.6. The Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved ends when:

2.2.4.4.6.1. A plan Provider with privileges at the treating Hospital assumes responsibility for the Member's care.

2.2.4.4.6.2. A plan Provider assumes responsibility for the Member's care through transfer.

2.2.4.4.6.3. The Contractor and the treating Provider reach an agreement concerning the Member's care.

2.2.4.4.6.4. The Member is discharged.

2.2.4.4.7. Nothing in this section shall preclude the Contractor from conducting a retrospective review consistent with this Contract regarding emergency and Post-Stabilization Care Services.

2.2.4.4.8. The Contractor shall be 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.

2.2.4.4.9. The Contractor shall not be financially responsible for outpatient emergency room services billed on a UB-04 for Members diagnosed with a primary substance use disorder. The Contractor shall be responsible for practitioner emergency room claims billed on a CO-1500 for Members diagnosed with substance use and/or mental health disorders.

2.2.4.4.10. The Contractor shall not be 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.

2.2.4.5. School-based services.

2.2.4.6. Targeted case management.

2.2.4.7. Alcohol and/or drug assessment.

2.2.4.8. Drug screening and monitoring.

2.2.4.9. Medication Assisted Treatment.

2.2.4.10. Coverage for Outpatient Hospital Services.

2.2.4.10.1. The Contractor's responsibility for outpatient hospital services is based on the diagnosis and billing procedures of the hospital.

2.2.4.10.1.1. For procedures billed in ANSI 837-I X12 format, the Contractor shall be financially responsible for all Medicaid services associated with a Member's outpatient hospital treatment, including all psychiatric and associated medical and facility services, labs, x-rays, supplies, and other ancillary services when:

2.2.4.10.1.1.1. The procedure(s) are billed on a UB-04 and ANSI 837-I X12 claim form.

2.2.4.10.1.1.2. The principal diagnosis is a covered psychiatric diagnosis.

2.2.4.10.1.2. For procedures billed in ANSI 837P X12 format, the Contractor shall be 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:

2.2.4.10.1.2.1. The procedure(s) is billed on a CO-1500 and ANSI 837-P X12 claim form.

2.2.4.10.1.2.2. The principal diagnosis is a covered behavioral health diagnosis.

2.2.4.11. Detoxification and related services including, but not limited to, the following:

2.2.4.11.1. Physical assessment of detox progression including vital signs monitoring.

2.2.4.11.2. Level of motivation assessment for treatment evaluation.

2.2.4.11.3. Provision of daily living needs.

2.2.4.11.4. Safety assessments.

2.2.5. Covered 1915(b)(3) Waiver (alternative) Services

2.2.5.1. The Contractor shall provide or arrange for the following 1915(b)(3) Waiver services to Members:

2.2.5.1.1. Vocational Services.

2.2.5.1.2. Intensive Case Management.

2.2.5.1.3. Prevention/Early Intervention Activities.

2.2.5.1.4. Clubhouse and Drop-in Centers.

2.2.5.1.5. Residential.

2.2.5.1.6. Assertive Community Treatment (ACT).

2.2.5.1.7. Recovery Services.

2.2.5.1.8. Respite Services.

2.2.5.2. Contractor shall comply with the requirements of the Uniform Service Coding Standards (USCS) Manual for billing procedure codes. The USCS Manual can be found on the Department's website.

2.2.5.3. The Contractor's providers shall be trained and its systems shall be able to submit the new ICD-10 codes no later than October 1, 2015.

2.2.5.3.1. DELIVERABLE: ICD-10 codes training and preparation completed.

2.2.5.3.2. DUE: October 1, 2015.

2.2.6. The Department will provide the Contractor with definitions in writing of services discussed in Section 2.2. The Department reserves the right to change and update these definitions as required and will provide the Contractor with the updated definitions.

2.3. EVIDENCE-BASED AND PROMISING PRACTICES

2.3.1. The Contractor shall implement evidence-based and promising practices as described in this section.

2.3.1.1. Contractors' implementation of these practices shall demonstrate fidelity to the tested model used for each evidence-based practice, when available, in order to assure the effectiveness of the service provided.

2.3.1.1.1. The Contractor may make adjustments for good cause, such as administering the practice in rural areas or to account for cultural differences.

2.3.1.2. Evidence-based and Promising Practices for Adults

2.3.1.2.1. During the term of the contract, the Contractor shall provide at least six (6) evidence-based or promising practices from the list of Adult Services below or offer its own evidence-based and promising practices in addition to the ones listed below.

2.3.1.2.1.1. Contractor may provide a combination of its own evidence based practices and select from the below list to meet the requirement of six (6) practices chosen.

2.3.1.2.1.2. The Contractor shall design two (2) evidence based practices for the co-occurring mental illness/substance use disorder population and shall measure performance against at least two (2) metrics of each of the selected practices annually.

2.3.1.2.2. Adult Services

2.3.1.2.2.1. Assertive community treatment.

2.3.1.2.2.2. Co-occurring Disorders.

2.3.1.2.2.3. Member-run/Peer Services.

2.3.1.2.2.4. Crisis services.

2.3.1.2.2.5. Illness management.

2.3.1.2.2.6. Psychiatric rehabilitation.

2.3.1.2.2.7. Psycho-education for families.

2.3.1.2.2.8. Behavioral health counseling and therapy, individual or group.

2.3.1.2.2.9. Supported employment.

2.3.1.2.2.10. Supported housing.

2.3.1.2.2.11. Adult behavioral health promotion.

2.3.1.2.3. The Contractor shall submit an Excel spreadsheet of the Evidence Based Practices (EBPs) chosen, metrics measured, rationale for any changes made to the EBPs, and historical results of the EBPs.

2.3.1.2.3.1. DELIVERABLE: Evidence Based Practices Spreadsheet.

2.3.1.2.3.2. DUE: August 30th of each contract year.

2.3.1.3. Evidence-based and Promising Practices Services for Children and Adolescents

2.3.1.3.1. The Contractor shall provide at least six (6) evidence-based or promising practices from the list of Child and Adolescent Services below or offer its own evidence-based and promising practices in addition to the ones listed below.

2.3.1.3.1.1. Contractor may provide a combination of its own evidence based practices and select from the below list to meet the requirement of six (6) practices chosen.

2.3.1.3.1.2. The Contractor must measure performance against at least two (2) metrics of each of the selected practices annually to ensure fidelity to the identified model for the following service categories: Family therapy; case management; child and adolescent psychotherapy; school-based services.

2.3.1.3.2. Children and Adolescent Services

2.3.1.3.2.1. Brief hospitalization for suicidal children and adolescents.

2.3.1.3.2.2. Crisis services.

2.3.1.3.2.3. Family Therapy.

2.3.1.3.2.4. Psychotherapy for children and adolescents.

2.3.1.3.2.5. Home-based services.

2.3.1.3.2.6. Intensive case management.

2.3.1.3.2.7. Psycho education for.

2.3.1.3.2.8. School-based services.

2.3.1.3.2.9. Behavioral health prevention interventions.

2.3.1.3.3. The Contractor shall submit an Excel spreadsheet of the Evidence Based Practices (EBPs) chosen, metrics measured, rationale for any changes made to the EBPs, and historical results of the EBPs.

2.3.1.3.3.1. DELIVERABLE: Evidence Based Practices Spreadsheet.

2.3.1.3.3.2. DUE: August 30th of each contract year.

2.3.2. The Department will provide the Contractor with definitions in writing of services discussed in Section 2.3. The Department reserves the right to change and update these definitions as required and will provide the Contractor with the updated definitions.

2.4. INTEGRATED AND COORDINATED CARE

2.4.1. Innovations Program for Integrating Care

2.4.1.1. The Contractor shall establish a centralized innovations program for integrating care to lead the development, implementation, and performance monitoring of advanced practices for integrating health care in the Contractor's Service Area. The program shall be one of the following:

2.4.1.1.1. An integrated provider site or practice that offers a high standard of care to Members and disseminates best practices and learnings to other providers in the Region's network.

2.4.1.1.2. A Region-wide improvement initiative in the Contractor's Service Area with the goal of promoting the integration of behavioral health services with either primary care services or public health care.

2.4.2. Coordination and Continuity of Care

2.4.2.1. Policies and Procedures

2.4.2.1.1. The Contractor shall maintain written policies and procedures. The policies and procedures shall address the following:

2.4.2.1.1.1. Timely coordination of the provision of Covered Services to its Members.

2.4.2.1.1.2. Service accessibility.

2.4.2.1.1.3. Attention to individual needs.

2.4.2.1.1.4. Continuity of care to promote maintenance of health and to maximize independent living.

2.4.2.1.1.5. The integration, coordination and provision of Covered Services in conjunction with other behavioral health care providers, physical health care providers, long term services and support providers, waiver services providers, pharmacists, county and state agencies, local public health agencies, and other provider organizations that may be providing wrap around services to the Member,

2.4.2.1.1.6. Ensuring that Members' privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 and 42 CFR Part 2.

2.4.2.2. Care Coordination Activities

2.4.2.2.1. The Contractor shall provide for Care Coordination, which shall address Members' need for integration of mental health services, substance use disorder services, and other health services. This includes identifying, providing, or arranging for services and/or coordinating with other agencies to ensure that the Member receives the health care and supportive services that will allow the Member to remain in her/his community.

2.4.2.2.1.1. This requirement is particularly critical for Medicaid clients receiving wrap around services under an HCBS waiver as described in Exhibit J entitled "Wrap Around Services."

2.4.2.2.1.2. Contractor shall ensure that providers (primarily, but not limited to, Community Mental Health Centers) communicate with and coordinate services with the Single Entry Point (SEP) care manager for each Member who participates in the Waiver for Persons with Mental Illness (HCBS-MI) or Waiver for the Elderly, Blind and Disabled (HCBS-EBD). Communication and coordination is also required with Assisted Living Residences (ALRs) or other supported community living arrangements in which HCBS waiver recipients live.

2.4.2.2.1.3. The Contractor shall also coordinate and provide Covered Services in conjunction with other behavioral health care providers, physical health care providers, long term care providers, waiver services providers, pharmacists, county and state agencies, and other provider organizations that may be providing wrap around services described in the attached document entitled "Wrap Around Services."

2.4.2.2.2. The Contractor shall coordinate with the Member's medical health providers to facilitate the delivery of health services, as appropriate.

2.4.2.2.2.1. The Contractor shall make reasonable efforts to assist individuals to obtain necessary medical treatment.

2.4.2.2.2.2. If a Member is unable to arrange for supportive services necessary to obtain medical care due to her/his behavioral health disorders, these supportive services shall be arranged for by the Contractor or another person who has an existing relationship with the Member, whenever possible.

2.4.2.2.3. The Contractor shall work closely and collaboratively with the Regional Care Collaborative Organizations (RCCOs) on care coordination activities as the RCCOs will also be providing care coordination activities to the Medicaid population.

2.4.2.3. Strategies for Advancing Integration

2.4.2.3.1. The Contractor shall work with providers, RCCOs, and other entities to achieve greater integration of care. While the capabilities and competencies of systems and providers in the state vary widely, the Contractor shall make ongoing efforts to continuously improve care and advance providers to higher levels of integrated care.

2.4.2.4. Special Populations and Complex Members

2.4.2.4.1. The Contractor shall ensure that all Members including those who are involved in multiple systems and those who have multiple needs receive covered, medically necessary care.

2.4.2.4.2. The Contractor shall provide for care coordination and continuity of care for the listed populations as follows:

2.4.2.4.2.1. Members residing in long-term care/nursing facilities.

2.4.2.4.2.1.1. The Contractor shall provide outreach, a delivery system and support to nursing facilities and assisted living residences in its service area to determine the best approach to serving their Medicaid residents.

2.4.2.4.2.1.2. The Contractor shall provide medically necessary, covered behavioral health services on-site in nursing facilities and assisted living residences for Members who cannot reasonably travel to a service delivery site for their services. Residents able to travel to service delivery sites may be required to receive their behavioral health services at a delivery site. The Contractor shall work collaboratively with nursing facilities and assisted living residences in its service area to jointly determine which residents are and are not able to travel to service delivery sites.

2.4.2.4.2.1.3. The Contractor shall provide outreach and coordination for the provision of mental health and substance use disorder services for Members in nursing facilities and assisted living residences in its region. This outreach shall occur on a monthly basis.

2.4.2.4.2.1.4. The Contractor shall assign each nursing facility and assisted living residence in the Contractor's region a primary contact from the Contractor's organization who will ensure Members are receiving necessary behavioral health services and who will help problem solve any Member issues that may arise in the provision of those services.

2.4.2.4.2.1.5. The Contractor shall establish an ongoing quarterly meeting with all nursing facilities and assisted living residences in its region to address outstanding issues, Member concerns and any other issues that arise in the delivery of behavioral health services to nursing facility and assisted living Members.

2.4.2.4.2.1.6. The Contractor shall provide Pre-Admission and Resident Review (PASRR) Level II requirements and services to Members entering nursing facilities.

2.4.2.4.2.1.7. The Contractor shall provide any specialized services identified on the PASRR Level II assessment that are covered behavioral health services.

2.4.2.4.2.1.8. The Contractor shall implement and follow PASRR admission processes and procedures developed by the Department.

2.4.2.4.2.1.9. The Contractor shall provide medically necessary covered services to Members that do not meet PASRR diagnosis requirements but who do have covered BHO diagnoses.

2.4.2.4.2.2. Dually or multiply eligible Members

2.4.2.4.2.2.1. Medicaid is the payer of last resort for dual or multi- eligible Members. The Contractor shall ensure that behavioral health services are provided to dual or multi- eligible Members and assist Members in finding qualified Medicare providers who are willing to provide covered services. If qualified Medicare providers cannot be identified or accessed, the Contractor shall provide medically necessary covered behavioral health services under the Contract. The Contractor shall describe how dually eligible Members are served by its Provider Network in the network plan described in Section 2.5.9.2.

2.4.2.4.2.3. Dually or multi- diagnosed Members

2.4.2.4.2.3.1. The Contractor shall provide medically necessary behavioral health services to Members with non-covered diagnoses (TBI, DD, autism, etc.) when the Member presents with a co-occurring mental health or substance use disorder diagnosis.

2.4.2.4.2.3.2. The Contractor shall be responsible for all medically necessary covered services to treat the covered mental health or substance use disorder diagnosis and shall have a mechanism for working with developmental disability services, Community Centered Boards (CCBs), Single Entry Point agencies (SEPs), or other appropriate agencies/health care providers to secure agreement regarding the medical necessity of behavioral services to treat the covered behavioral diagnosis and resulting behaviors.

2.4.2.4.2.3.3. The Contractor shall provide care coordination to Members with co-occurring diagnoses, including appointment setting, assistance with paperwork, and follow-up to ensure linkage with the appropriate agency. If the Contractor determines that the Member does not have a covered behavioral health diagnosis based upon criteria outlined in this Contract and exhibits, Contractor shall inform the Member about how services may be obtained, pursuant to federal Medicaid managed care rules, and refer them to the appropriate providers (e.g., RCCOs, CCBs, SEPs, etc.).

2.4.2.4.2.4. Members with special health care needs

2.4.2.4.2.4.1. The Contractor shall share with all health plans, RCCOs, and providers serving each Member with special health care needs the results of its identification and assessment of the Member's needs to prevent duplication of those activities. The Contractor shall provide care coordination, which shall address the Member's need for integration of behavioral health and other services.

2.4.2.4.2.5. Members involved with the correctional system

2.4.2.4.2.5.1. The Contractor shall collaborate with agencies responsible for the administration of jails, prisons and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth Members.

2.4.2.4.2.5.2. The Contractor shall ensure Members receive medically necessary initial services after release from correctional facilities and shall ensure ongoing services thereafter. The Contractor shall provide the continuation of medication management and other behavioral health care services prior to community reentry and continually thereafter. The Contractor shall have a plan in place for monitoring and reporting results semi-annually to the Department. Contractor shall include historical results, analysis, and trends in subsequent semi-annual submissions to the Department.

2.4.2.4.2.5.2.1. DELIVERABLE: Post-Correctional System Member Service Results.

2.4.2.4.2.5.2.2. DUE: Semi-annually, by August 31st and February 28th of each year.

2.4.2.4.2.5.3. The Contractor shall designate a staff person as the single point of contact for working with correctional facilities (e.g., jails, prisons, and juvenile detention facilities, etc.) that may release incarcerated or detained Members into the Contractor's Service Ares.

2.4.2.4.2.5.4. The Contractor shall collaborate with correctional facilities to obtain medical records or information for Members who are released into the Region, as necessary for treatment of behavioral health conditions.

2.4.2.4.2.5.5. The Contractor shall work with the Department on any other initiatives including but not limited to Medicaid eligibility issues related to Members involved or previously involved with the state correctional system.

2.4.2.4.2.5.6. The Contractor shall propose innovative strategies, the use of new or existing technology, communication protocols/strategies and coordination techniques with the courts, parole officers, police officers, correctional facilities and their staff, and other individuals needed to meet the requirements of Members involved with the correctional system. This information shall be provided on a template provided by the Department or Contractor. The template is subject to approval by the Department.

2.4.2.4.2.5.6.1. DELIVERABLE: Correctional System Strategies and Techniques.

2.4.2.4.2.5.6.2. DUE: Within sixty (60) days after the Operational Start Date or later if agreed upon by the Department and the Contractor.

2.4.2.4.2.6. Female Medicaid Members for a period of one (1) year post-partum

2.4.2.4.2.6.1. The Contractor shall develop specialized treatment and service plans to ensure that the behavioral and physical needs of the mother and child are being met.

2.4.2.4.2.7. Child/Youth Members in out-of-home placements, foster care, and subsidized adoptions

2.4.2.4.2.7.1. Contractor's Provider Network shall include clinical staff who have expertise in identifying and addressing clinical issues that are unique to children and families involved in the child welfare system. Staff shall be familiar with the unique needs of child welfare Members, be able to provide psycho-educational as well as practical therapeutic interventions and know of and refer families to community resources that may be helpful.

2.4.2.4.2.8. Transitioning Members from Colorado Mental Health Institutes (Ft. Logan and Pueblo) and Hospitals

2.4.2.4.2.8.1. The Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Mental Health Institutes located at Ft. Logan and Pueblo to safe and alternative environments. Contractor shall participate in discussions and care coordinate with the Institutes, and the Contractor shall have plans in place to provide medically necessary covered services once the Member has been discharged from the Mental Health Institute.

2.4.2.4.2.8.2. The Contractor shall work with local counties and hospitals in their region in order to transition children from hospitals to safe and alternative step down environments (e.g., home, residential, etc.). Contractors shall meet with local counties and hospitals after contracts have been awarded in order to develop and maintain protocols and procedures for how these transitions will take place in order to ensure continuity of care and continuation of services.

2.4.2.4.2.8.3. The Contractor shall work with the Institutes to execute communication and transition plans for Members.

2.4.2.4.2.8.4. The Contractor shall assign a liaison to serve as a regular point of contact with State Mental Health Institute staff and Members who will return to or enter the Contractor's geographic service area. The Contractor's liaison, or their designee, shall engage in the following activities:

2.4.2.4.2.8.4.1. Monthly treatment planning meetings, when requested by the Department or Institute.

2.4.2.4.2.8.4.2. Discharge planning meetings.

2.4.2.4.2.8.4.3. Face-to-face planning with client.

2.4.2.4.2.8.4.4. Prompt in-person, email, telephone, and fax communication with treatment Providers sufficient to arrange a successful discharge from the Institute.

2.4.2.4.2.8.5. Once the Contractor's Members are discharged from an Institute, the Contractor shall be responsible for on-going treatment, case

management and other behavioral health services determined to be medically necessary.

2.4.2.4.2.8.6. The Contractor shall participate (with one (1) representative) on the Institute's Person Centered Planning Board as requested by the Department and/or Institutes.

2.4.2.5. Community Partners

2.4.2.5.1. The Contractor shall form relationships with community partners that provide non-Program and non-Medicaid services for Member needs that may affect health. As part of care coordination, the Contractor shall leverage awareness of the community resources and relationships with community partners to assist in linking Members with appropriate services.

2.4.2.5.2. The Contractor shall update and submit the directory and regional map of community partners to the Department annually.

2.4.2.5.2.1. DELIVERABLE: Directory and Regional Map of Community Partners.

2.4.2.5.2.2. DUE: Annually on August 30th.

2.4.2.6. Alignment with Systems

2.4.2.6.1. In addition to community partners, the Contractor shall work with other government agencies that may provide services to Members. These agencies include:

2.4.2.6.1.1. Colorado Department of Health Care Policy and Financing, Division of Development Disabilities.

2.4.2.6.1.2. Colorado Department of Human Services, Child Welfare.

2.4.2.6.1.3. Colorado Department of Human Services, Office of Behavioral Health.

2.4.2.6.1.4. Colorado Department of Public Health and Environment, STD/HIV Section.

2.4.2.6.1.5. Colorado Department of Public Health and Environment.

2.4.2.6.1.6. Colorado Department of Corrections

2.4.2.6.1.7. Colorado Prevention Services Division

2.4.2.7. Program Improvement Advisory Committee

2.4.2.7.1. The Contractor shall create a Program Improvement Advisory Committee to provide input into the Contractor's implementation of the Program and the

Contractor's own performance improvement program. The Program Improvement Advisory Committee shall:

2.4.2.7.1.1. Be directed and chaired by one of Contractor's Key Personnel.

2.4.2.7.1.2. Have a formal, documented membership and governance structure.

2.4.2.7.1.3. Have a diverse membership, representative of the Contractor's Region, which includes members representing at least the following:

2.4.2.7.1.3.1. Members

2.4.2.7.1.3.2. Members' families

2.4.2.7.1.3.3. Advocacy groups and organizations

2.4.2.7.1.3.4. Network provider representatives

2.4.2.7.1.3.5. Representative(s) from the overlapping RCCO(s)

2.4.2.7.1.3.6. Other Medicaid providers

2.4.2.7.1.3.7. Nursing Facilities/Assisted Living Residences

2.4.2.7.1.3.8. Charitable, faith-based or service organizations within the community

2.4.2.7.1.3.9. Other state agencies and local counties (e.g., child welfare)

2.4.2.7.1.4. Hold regularly scheduled meetings, no less often than on a quarterly basis.

2.4.2.7.1.5. Open all scheduled meetings to the public.

2.4.2.7.1.6. Post the minutes of each meeting on the Contractor's website within seven (7) days of each meeting and forward a copy of these minutes to the Department.

2.4.2.7.1.6.1. DELIVERABLE: Program Improvement Advisory Committee Minutes.

2.4.2.7.1.6.2. DUE: Within seven (7) days of each meeting.

2.5. SERVICE DELIVERY

2.5.1. The Contractor shall ensure that services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to high quality, general and specialized care, from a comprehensive, integrated Provider Network.

2.5.2. The Contractor's Provider Network shall include, but not be limited to, the following:

2.5.2.1. Community Mental Health Centers (CMHC).

2.5.2.2. Essential Community Providers (ECP).

2.5.2.2.1. The Contractor shall offer contracts to all ECPs located in the Contract Service Area. The Contractor is not required to contract with every ECP that provides behavioral health services in its geographic area.

2.5.2.3. Federally Qualified Health Centers (FQHC).

2.5.2.3.1. The Contractor shall offer contracts to all FQHCs located in the Contract Service Area. The Contractor is not required to contract with every FQHC that provides behavioral health services in its geographic area.

2.5.2.3.2. The Contractor shall provide direct payment to FQHCs for Covered Services provided to its Members. Payment shall be made at a rate of no less than one hundred percent (100%) of the Fee For Service encounter rate. For additional quality assurance and direction on what provider type is allowable to provide specific services, please see the Uniform Service Coding Standards (USCS) Manual.

2.5.2.4. School Based Health Centers (SBHCs).

2.5.2.5. Rural health clinics.

2.5.2.6. Community safety net clinics.

2.5.2.7. Substance use disorder providers.

2.5.2.8. Providers with experience serving individuals with complex needs as mentioned above, e.g. individuals with dual diagnoses and those with chronic physical conditions in addition to behavioral health needs.

2.5.2.9. Providers capable of billing both Medicare and Medicaid.

2.5.3. The Contractor shall have a system for credentialing providers.

2.5.3.1. DELIVERABLE: Provider Credentialing System.

2.5.3.2. DUE: Within fifteen (15) Business Days of the Operational Start Date.

2.5.4. The Contractor shall comply with the requirements outlined in this contract for Provider Credentialing and Monitoring.

2.5.5. The Contractor's overall service delivery system shall include:

2.5.5.1. Specific mechanisms for individual Member intake and assessment.

2.5.5.2. Service planning.

2.5.5.3. Care coordination.

2.5.5.4. Continuity of care.

2.5.6. Within its service delivery system, the Contractor shall promote the provision of behavioral health services by primary care physicians and behavioral health systems of care, and increase the co-location of providers.

2.5.7. The Contractor shall ensure that its service delivery system and Provider Network meets the needs of the Medicaid expansion, newly eligible Medicaid clients.

2.5.8. Access to Care

2.5.8.1. The Contractor shall ensure access to care for all Members in need of covered mental health and substance use disorder services through the provision of the following:

2.5.8.1.1. Varied geographic location of providers.

2.5.8.1.2. Minimum hours of provider operation shall include service coverage from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday, and emergency coverage twenty-four (24) hours a day, seven (7) days a week.

2.5.8.1.3. Extended hours of operation and service coverage shall be provided at least two days per week at clinic treatment sites, which may include additional morning, evening or weekend hours, to accommodate Members who are unable to attend appointments during standard business hours, especially for children and adolescents in school. Contractor shall encourage individual network providers to offer flexibility of appointment times to Members whenever possible.

2.5.8.1.4. Providers located throughout the Contractor's service area within thirty (30) miles or thirty (30) minutes travel time to the extent such services are available.

2.5.8.1.5. Community-based access.

2.5.8.1.5.1. The Contractor shall provide behavioral health services in multiple community-based venues, based on a determination that the services are medically necessary, appropriate to the Member's needs, and that providing treatment at an alternative site does not put the provider's safety at undue risk. Alternative treatment sites may include, but are not limited to:

2.5.8.1.5.1.1. Schools.

2.5.8.1.5.1.2. Juvenile detention centers.

2.5.8.1.5.1.3. Federally qualified health centers.

2.5.8.1.5.1.4. Homeless shelters.

2.5.8.1.5.1.5. Acute care facilities.

2.5.8.1.5.1.6. Skilled nursing and assisted living residences.

2.5.8.1.5.1.7. Members' homes.

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

2.5.8.1.7. Member Call-In Services

2.5.8.1.7.1. The Contractor shall develop and manage a call center staffed by trained, customer-oriented customer services representatives.

2.5.8.1.7.2. The Contractor shall have written policies and procedures for the call center.

2.5.8.1.7.2.1. DELIVERABLE: Call Center Policies and Procedures.

2.5.8.1.7.2.2. DUE: Within sixty (60) days after the Operational Start Date.

2.5.8.1.7.3. The Contractor shall offer at least one (1) twenty-four (24)-hour-a-day toll-free telephone customer service information line and a telecommunications device for the deaf (TDD). Both phone numbers must be published in local phone books, on the Contractor's website, and in other written materials to Members.

2.5.8.1.7.4. The Contractor shall track phone statistics, that include:

2.5.8.1.7.4.1. Call answer rate (total answered by staff ÷ total received).

2.5.8.1.7.4.2. Call abandonment rate (total not answered by staff ÷ total received).

2.5.8.1.7.4.3. Member identification.

2.5.8.1.7.4.4. Reason for Member's call.

2.5.8.1.7.5. The Contractor shall monitor phone calls and obtain information on Member satisfaction with the information and customer services telephone lines.

2.5.8.1.7.6. The Contractor shall evaluate the effectiveness of the call-in services semi-annually and submit a report to the Department. This report shall include, but is not limited to, standards utilized for comparisons, analysis, and the improvements made.

2.5.8.1.7.6.1. DELIVERABLE: Call-in Services Effectiveness Evaluation Report.

2.5.8.1.7.6.2. DUE: Semi-annually, by August 31st and February 28th of each year.

2.5.8.1.8. Identification of Members who unexpectedly miss appointments or discontinue treatment.

2.5.8.1.8.1. The Contractor shall take appropriate and timely steps to contact Members to determine if there is a problem that can be resolved and to promote continuation of services.

2.5.8.1.8.2. The Contractor shall recognize that different strategies and levels of effort are appropriate for different populations (e.g. age groups, diagnosis, severity of illness, culture, language, etc.) and conduct outreach efforts that are appropriate for different populations, using attempts that are calculated to ensure verifiable contact.

2.5.8.1.9. Ensure Covered Services included in the Contract are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.

2.5.8.1.10. Criteria for discharge from treatment/services.

2.5.8.1.10.1. 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.

2.5.8.1.11. Standards for timeliness of service include:

2.5.8.1.11.1. Emergency services shall be available by phone, including TTY accessibility, within fifteen (15) minutes of the initial contact, 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.

2.5.8.1.11.2. Urgent care shall be available within twenty-four (24) hours from the initial identification of need.

2.5.8.1.11.3. Routine services shall be available upon initial request within seven (7) Business Days. Routine services include, but are not limited to an initial individual intake and assessment appointment. The Contractor shall not place Members on waiting lists for initial routine service requests.

2.5.8.1.11.4. Outpatient follow-up appointments shall be available within seven (7) Business Days after discharge from an inpatient psychiatric hospitalization or residential facility.

2.5.8.1.11.5. Ongoing mental health and substance use disorder services shall be scheduled and continually provided for within two (2) weeks from an initial assessment or intake appointment. Ongoing services include, but are not limited to:

2.5.8.1.11.5.1. Assignment to a therapist and individual/group outpatient therapy.

2.5.8.1.11.6. Routine outpatient appointments following intake/initial assessment shall occur at least three (3) times within forty-five (45) days.

2.5.8.1.11.7. Medication management appointment timeliness may vary according to the Member's circumstances, needs and/or agreed upon treatment/care plan. If/when same day access policies are utilized for medication management appointments, the Contractor shall ensure that there is a subsequent policy in place which allows Members to schedule an advanced appointment in the event that same day access does not appropriately meet the needs of the Member.

2.5.8.1.11.8. The Contractor shall have a system in place for providing after hour authorizations to providers. This process shall include a process for authorizations that occur during weekends and holidays.

2.5.8.1.11.8.1. DELIVERABLE: After Hour Authorization Process.

2.5.8.1.11.8.2. DUE: Within fifteen (15) days after the Operational Start Date.

2.5.8.1.11.9. The Contractor shall allow for Member and family flexibility on scheduling appointments and shall not limit when Members can schedule appointments during regular Business Hours.

2.5.8.1.11.10. The Contractor shall allow for provider flexibility when authorizations were not obtained prior to treatment when the diagnosis is later determined to be behavioral in nature.

2.5.8.1.11.11. The Contractor shall require provider authorizations for twenty-four (24) hour care (inpatient and residential services) and intensive services (partial, day treatment, Acute Treatment Unit).

2.5.8.1.11.11.1. The provider authorizations shall attest, through the UM process, that a discharge plan involving family/Member input and signed by the family/Member has been included in the patient record within forty eight (48) hours of Member's admission to an inpatient or residential setting or after intensive services have begun, or when the Member is clinically able to participate meaningfully in discharge planning.

2.5.8.1.11.11.2. In any case where the discharge plan is delayed later than forty eight (48) hours after admission, the patient record shall include documentation of the clinical reason for the delay.

2.5.8.1.11.11.3. Contractor shall conduct routine chart audits of these records to ensure appropriate documentation is present.

2.5.8.1.11.11.4. Contractor shall amend their provider agreements to include the above provisions, and this shall be added to the documentation requirements.

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

2.5.9. Provider Network

2.5.9.1. The Contractor shall establish and maintain a comprehensive Provider Network capable of serving the mental health and substance use disorder needs of all Members in the Program.

2.5.9.1.1. A comprehensive Provider Network shall take into account:

2.5.9.1.1.1. The anticipated Medicaid enrollment.

2.5.9.1.1.2. The expected utilization of services.

2.5.9.1.1.3. Standards of appropriate case load for providers.

2.5.9.1.1.4. Characteristics and health care needs of specific Medicaid populations represented in the geographic service area.

2.5.9.2. The Contractor shall create a Network Plan that shall, at a minimum, address all of the following:

2.5.9.2.1. The numbers, types and specialties of providers, particularly substance use disorder providers, psychiatrists and child psychiatrists, and those who serve

children in the child welfare system, required to furnish covered services and care coordination.

2.5.9.2.2. The number of Network Providers accepting/not accepting new Medicaid Members by provider type and smaller geographic breakdown within service area.

2.5.9.2.3. The number of network providers that specialize in co-occurring diagnoses and treatment including those providers that are able to serve Members with a behavioral health diagnosis (mental health or substance use disorder) that may have an additional co-occurring non covered diagnosis (Traumatic Brain Injury (TBI), Developmental Disabilities (DD), Autism, etc.)

2.5.9.2.4. The geographic location of providers in relationship to where Medicaid Members live.

2.5.9.2.5. Members' potential physical barriers to accessing providers' locations.

2.5.9.2.6. The cultural and language expertise of providers (including deaf and hard of hearing providers).

2.5.9.2.7. 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.

2.5.9.2.8. Credentialing standards that will be used to credential providers into the Contractor's network.

2.5.9.2.8.1. The Contractor's credentialing standards shall comply with the requirements outlined in this Contract.

2.5.9.2.9. How providers in the Contractor's Provider Network will meet The Americans with Disabilities Act of 1990 (ADA) access standards or offer alternative locations that meet these standards.

2.5.9.2.10. How providers in the Contractor's Provider Network will be able to meet ADA communication requirements.

2.5.9.2.11. The number of network providers specializing in trauma-informed care, assertive community treatment, child development, child welfare involvement, dually diagnosed populations (mental health and substance use), treatment foster care and the geriatric populations.

2.5.9.2.12. The expected number of staff and hours that mental health clinicians will be present in assisted living residences and nursing facilities on a weekly basis to ensure that PASRR Level II requirements and medically necessary behavioral health needs are being met.

2.5.9.2.13. The number of providers in the Contractor's 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 Contractor's region.

2.5.9.2.14. The frequency and types of trainings that will be given to providers in the Contractor's network.

2.5.9.2.14.1. Trainings shall take place on at least a semi-annual basis and include, but not be limited to, the topics of:

2.5.9.2.14.1.1. Access to Care standards.

2.5.9.2.14.1.2. Member transition issues (e.g., how to assist members with transitioning from one BHO to another).

2.5.9.2.14.1.3. BHO responsibilities and services to the community.

2.5.9.2.14.1.4. Grievances, appeals, and member rights.

2.5.9.2.14.1.5. Eligibility requirements for Medicaid, the Medicaid application process and assisting individuals with benefit acquisition.

2.5.9.2.15. DELIVERABLE: Network Plan.

2.5.9.2.16. DUE: Within thirty (30) days of the Operational Start Date.

2.5.9.3. The Contractor shall reach out and offer to contract with Essential Community Providers located in the Contractor's geographic service area, as defined in C.R.S. § 25.5-5-404.2.

2.5.9.4. The Contractor's network shall include both Essential Community Providers and other private/non-profit providers.

2.5.9.5. If the Contractor is unable to provide covered 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. The Contractor shall maintain co-location of staff in high volume physical health locations and support smaller, dispersed physical health providers with the behavioral health needs of their covered population.

2.5.9.6. The Contractor shall establish relationships with and offer to contract with RCCOs. Contractor shall coordinate care with a network of specialty providers including but not limited to RCCOs, CCBs, DD/TBI/autism providers, SBHCs, FQHCs, rural

health clinics, community safety net clinics, and other Essential Community Providers.

2.5.9.7. The Contractor shall create a Patient Load Monitoring Plan and shall implement the Patient Load Monitoring Plan to monitor patient loads in its Provider Network to effectively plan for future needs and recruit providers as necessary to assure adequate access for Members to all covered services.

2.5.9.7.1. DELIVERABLE: Patient Load Monitoring Plan.

2.5.9.7.2. DUE: Within fifteen (15) days of the Operational Start Date.

2.5.9.8. The Contractor shall not enroll IHS/Tribal 638 providers in its BHO Provider Network. The Contractor's Network Providers shall serve tribal members who seek covered services and the Contractor will receive capitation payments for any Medicaid eligible tribal member. When Medicaid services are sought from IHS/Tribal 638 providers, those providers shall bill the Department's fiscal agent directly.

2.5.9.9. Upon request by the Department, the Contractor and Department shall discuss adding additional Providers to the Contractor's provider network who meet the Contractor's credentialing requirements and are willing to agree to the Contractor's provider contract.

2.5.9.10. Trauma Informed Care

2.5.9.10.1. The Contractor shall ensure that all Providers are trained in trauma informed care and that all treatment foster care providers are implementing trauma informed care. Trauma-informed care shall include:

2.5.9.10.1.1. A system wide understanding of trauma prevalence.

2.5.9.10.1.2. The impact of trauma on mental health and substance use.

2.5.9.10.1.3. The specific trauma impact of child abuse and neglect and trauma informed care principles.

2.5.9.10.2. The Contractor shall demonstrate that it has an adequate number of therapists trained in trauma specific treatments for both adults and children in their Provider network. This shall be reported on the network adequacy reports by indicating what trauma treatment the Provider is proficient in.

2.5.9.11. Treatment Foster Care

2.5.9.11.1. The Contractor shall demonstrate an adequate number of Providers who can provide treatment for children in foster care, which includes clinicians who are experienced in working with the child welfare system. This shall be reported on the network adequacy reports by indicating Providers who are proficient with Treatment Foster Care.

2.5.9.11.1.1. Adequacy shall be determined by the Department based upon information provided by the Contractor and counties. The Contractor's documentation

shall include the number of children in foster care needing services and capacity of the Contractor's providers in their network.

2.5.9.11.2. The Contractor is responsible for the treatment portion of Treatment Foster Care and is not responsible for the selection and payment of the foster care parent, which is provided by the county Department of Human Services.

2.5.10. Intake and Assessment

2.5.10.1. The Contractor shall ensure that each Member seeking to access services receives an individual intake and assessment for the level of care needed.

2.5.10.1.1. Group orientations at service locations may be offered for adult Members, if desired and appropriate for Member characteristics, provided that no personal health information is shared.

2.5.10.1.1.1. Group orientations may not take the place of an individual Member intake and assessment with a qualified clinician.

2.5.10.1.2. The Contractor's intake and assessment process shall address developmental, cultural and linguistic needs of each Member.

2.5.10.1.3. The Contractor shall ensure that Members are screened for mental illness, trauma and substance use disorders and assist Members in accessing needed care.

2.5.10.1.4. Intake and assessment appointments shall be scheduled for all Medicaid Members on an equal basis, regardless of whether or not a Member is accessing services in his/her assigned BHO.

2.5.10.1.5. The Contractor shall cooperate with other BHOs in sharing information, arranging payment for services, or transferring benefits without undue intervention by the Member and/or family members.

2.5.10.2. The Contractor shall follow written criteria currently approved by the Department for use in assessing and treating Members that present with co-occurring, non-covered diagnoses including developmental disabilities, autism, and traumatic brain injury as shown in Exhibits I and J.

2.5.10.3. For Members with a behavioral health (mental health or substance use disorder) covered diagnosis and a co-occurring non-covered diagnosis (such as autism, traumatic brain injury, developmental disability, etc.), the Contractor shall provide medically necessary covered services for the behavioral health diagnosis.

2.5.11. Service Planning

2.5.11.1. The Contractor shall have a service planning system, which utilizes the information gathered in the Member's intake and assessment to build a comprehensive service plan. The service plan may also be known as a treatment plan or a Member care plan, and shall include:

2.5.11.1.1. Measurable goals related to the chief complaint.

2.5.11.1.2. Strategies to achieve the stated goals and a mechanism for monitoring and revising the service plan as appropriate.

2.5.11.2. The Contractor shall create an individualized, culturally sensitive service plan, developed by the Member and/or the designated Member representative and the Member's provider or treatment team for each Member seeking services. The

service plan shall utilize the Member's strengths, and shall be signed by the Member as well as the reviewing professional.

2.5.11.2.1. If a Member chooses not to sign his/her service plan, documentation shall be provided in the Member's medical record stating the Member's reason for not signing the plan.

2.5.11.3. Service planning shall take place annually or if there is a change in the Member's level of functioning and care needs.

2.5.11.4. Service plans shall be appropriate to the treatment setting especially for integrated settings.

2.5.11.5. The Contractor shall coordinate with County departments of human/social services in regards to children and youth in out-of-home placements, including kinship care, foster care and subsidized adoptions.

2.5.11.5.1. The Contractor shall collaborate with the Colorado Department of Human services and their local counties to ensure that children who have had a positive screen for trauma receive a formal follow-up trauma assessment and trauma informed covered services (if indicated) provided by the Contractor.

2.5.11.5.2. The Contractor shall coordinate behavioral health referrals and services with county case workers, and initiate/maintain contact with case workers on an ongoing basis regarding child/adolescent Members as well as adult Members involved in child welfare that have children in their care. The Contractor shall ensure that therapists and case managers coordinate with county case workers regarding significant events which include, but are not limited to, discharge from treatment, significant clinical decompensation, and no shows.

2.5.11.5.3. The Contractor shall identify a person within its organization who can serve as a main point of contact for the county departments of human/social services. The name and contact information for this person shall be sent to all counties within the Contractor's jurisdiction and to the Department. Any changes to this person shall be communicated to the counties and Department within five (5) Business Days of the change.

2.5.11.5.3.1. DELIVERABLE: Human/Social Services Point of Contact Identification.

2.5.11.5.3.2. DUE: Within thirty (30) days after the Effective Date.

2.5.11.5.3.3. DELIVERABLE: Human/Social Services Point of Contact Identification Update.

2.5.11.5.3.4. DUE: Within five (5) Business Days of the change.

2.5.11.6. The Contractor shall provide trainings to county case workers and county management on the function and duties of the Contractor, access to care standards, available services, provider network, and other relevant topics as appropriate. At a minimum, trainings to the County shall occur on an annual basis. The Contractor shall post trainings and information (including but not limited to the above mentioned requirements) to their website.

2.5.12. Cultural Competency

2.5.12.1. The Contractor shall facilitate culturally and linguistically appropriate care in compliance with 42 CFR §438.206(c)(2).

2.5.12.2. In addition, the Contractor shall do the following:

2.5.12.2.1. Develop, implement, and promote a written strategic Cultural Competency Plan. The Cultural Competency Plan shall outline: clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

2.5.12.2.1.1. Policies shall support the provision of health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.

2.5.12.2.1.2. The Contractor shall have sufficient staff with cultural competency to implement and oversee compliance with the Contractor's Cultural Competency Plan and its policies.

2.5.12.2.1.3. DELIVERABLE: Cultural Competency Plan.

2.5.12.2.1.4. DUE: Within thirty (30) days after the Operational Start Date.

2.5.12.2.2. Identify Members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to:

2.5.12.2.2.1. Inquiries conducted by the Contractor of the language proficiency of Members during the Member's orientation visit or while being served by participating providers.

2.5.12.2.2.2. Improving access to health care through community outreach and Contractor publications.

2.5.12.2.3. Develop and/or provide cultural competency training programs, as needed, to network providers and Contractor staff regarding:

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

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

2.5.12.2.4. Conduct initial and bi-annual organizational self-assessments of cultural competency activities.

2.5.12.2.4.1. DELIVERABLE: Initial Organizational Self-Assessment.

2.5.12.2.4.2. DUE: Within thirty (30) days after the Operational Start Date

2.5.12.2.4.3. DELIVERABLE: Bi-annual Organizational Self-Assessment.

2.5.12.2.4.4. DUE: Annually by December 31st and June 30th.

2.5.12.2.5. Integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, Member satisfaction assessments, provider audits, and staff performance evaluations.

2.5.12.2.6. Develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers including, but not limited to, providers who represent racial and ethnic communities, the deaf and hard of hearing community, disability community, and other culturally diverse communities being served.

2.5.12.2.6.1. The Contractor shall include a mechanism for including in its provider network providers who are from diverse communities with cultural and linguistic competence to provide services to the target community. Mechanisms may include the use of telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds.

2.5.12.2.6.2. DELIVERABLE: Culturally Competent Provider Recruitment and Retention Strategy.

2.5.12.2.6.3. DUE: Within thirty (30) days after the Operational Start Date.

2.5.12.2.7. Provide access to interpretative services by a qualified interpreter for deaf or hard of hearing Members in such a way that it shall promote accessibility and availability of covered services.

2.5.12.3. Translation for Oral and Written Communications

2.5.12.3.1. The Contractor shall provide language assistance services, including bilingual staff and interpreter services, at no cost to any Member with limited English proficiency. Language assistance shall be provided at all points of contact, in a timely manner and during all hours of operation.

2.5.12.3.2. The Contractor shall assure the competence of language assistance provided to limited English proficient Members by interpreters and bilingual staff.

2.5.12.3.2.1. Family and friends shall not be used to provide interpretation services except by request of the Member.

2.5.12.3.3. The Contractor shall provide to Members, in their preferred language, verbal offers informing them of their right to receive language assistance services. The Contractor shall provide written notices of this right to Members in their preferred language, upon request.

2.5.12.3.4. The Contractor shall make available Member-related materials that are written at no higher than a sixth (6th) grade English reading level and comparable numeracy level.

2.5.12.3.5. The Contractor shall post signage in the languages of the most commonly encountered groups (e.g., English and Spanish) and/or groups represented in the service area.

2.5.12.3.6. The Contractor shall develop Interpreter Policies and Procedures on how the Contractor will handle requests from participating providers for interpreter services by a qualified interpreter.

2.5.12.3.6.1. This shall occur particularly in service areas where language may pose a barrier so that participating providers can: (i) conduct the appropriate assessment and treatment of non-English speaking Members (including Members with a communication disability) and (ii) promote accessibility and availability of covered services, at no cost to Members.

2.5.12.3.6.2. DELIVERABLE: Interpreter Policies and Procedures.

2.5.12.3.6.3. DUE: Within sixty (60) days after the Operational Start Date.

2.5.13. Early and Periodic Screening, Diagnostic and Treatment Services

2.5.13.1. The Contractor shall notify Members of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) and is responsible for ensuring that children and their families are able to access the services appropriately and that the program requirements are met.

2.5.13.1.1. Contractors are encouraged to refer children and their families to the Healthy Communities program in their area for additional information, community and medical referrals, transportation information, appointment assistance, missed appointment follow up, and administrative case management. For resources regarding the Healthy Communities program, please visit www.colorado.gov/hcpf and search "healthy communities."

2.5.13.2. EPSDT include, but is not limited to:

2.5.13.2.1. Screening.

2.5.13.2.2. Vision.

2.5.13.2.3. Dental.

2.5.13.2.4. Hearing.

2.5.13.2.5. Diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure.

2.5.13.3. The Contractor shall share PHI with the Department's EPSDT Outreach and Case Management agencies (Healthy Communities) as allowable under HIPAA for treatment, payment and operations purposes, without requiring any special releases or other permission from the Member, unless the sharing involves substance use disorder treatment from a 42 CFR Part 2 program.

2.5.13.4. In non-medical emergency situations, the Contractor shall have either written consent from a Member (or a Member's Authorized Representative) or a Qualified Service Organization (QSO) Agreement in order for a Part 2 program to share Member information regarding substance abuse disorder treatment with the Department's EPSDT Outreach and Case Management agencies.

2.5.13.5. The Contractor shall comply with all federal and state EPSDT regulations.

2.6. MEMBER AND FAMILY AFFAIRS

2.6.1. The Contractor shall have an Office of Member and Family Affairs.

2.6.1.1. The Office of Member and Family Affairs shall be headed by a Director who is an employee of the Contractor, to work with Members and families.

2.6.1.2. Responsibilities of the Office of Member and Family Affairs shall include, but not be limited to:

2.6.1.2.1. Member recovery

2.6.1.2.2. Involving the Member, Member's parent or legal guardian of a youth Member, family members and advocates in service planning, resource planning, Member-driven and Member-run services and activities, and when possible, employing Members.

2.6.1.2.3. The responsibilities of handling grievances and appeals.

2.6.1.2.4. Providing federally-required Member information.

2.6.1.2.5. Communicating and upholding Member rights.

2.6.2. The Contractor shall establish and maintain a Member/Family Advisory Board composed of the Contractor, Members and family representatives. The purpose of the Member/Family Advisory Board is to collaborate with and provide ongoing input to the Contractor about programs and services, Member rights, and other key components of the Program.

2.6.3. The Contractor shall participate in the Department's Behavioral Health Advisory Committee.

2.6.4. Member contributions shall be valued and sought in areas of program development, policy development, policy formation, program evaluation, quality assurance, system designs, education of behavioral health service providers, and the provision of direct services as employees of the provider system. Therefore, consumers shall be included in meaningful numbers in all these activities. In order to maximize their potential contributions, their involvement shall be supported in ways that promote dignity, respect, acceptance, integration and choice. Support provided shall include whatever financial, educational or social assistance is required to enable their participation.

2.6.5. Grievances and Appeals

2.6.5.1. The Contractor shall comply with 10 CCR 2505-10, Section 8.209, of the Medicaid state rules for Managed Care Grievance and Appeals Processes. The Contractor shall participate in all State fair hearings regarding appeals and other matters arising under this contract.

2.6.5.2. If the Department is contacted by a Member, family members of a Member, advocates, the Ombudsman for Medicaid Managed Care, and other individuals/entities 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.

2.6.6. Member Services

2.6.6.1. Policies and Procedures

2.6.6.1.1. The Contractor shall have written policies and procedures to implement the requirements of this section.

2.6.6.2. Member Input

2.6.6.2.1. The Contractor shall seek Member input on all policies and procedures related to member services.

2.6.6.3. Cultural Competency

2.6.6.3.1. The Contractor shall offer and provide language assistance services in all languages, including bilingual staff speaking the prevalent language(s) and interpreter services, at no cost to each Member with limited English proficiency. Language assistance services shall be available at all points of contact, in a timely manner and during all hours of operation.

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

2.6.6.3.2. The Contractor shall provide language assistance services when a Member asks. The Contractor shall also make verbal offers and provide written notices to Members informing them of the right to receive language assistance services. The services shall be given in the language that the Member requests.

2.6.6.3.3. The Contractor shall ensure the competence of language assistance provided to limited English proficient Members by interpreters and bilingual staff. Family and friends shall not be used to provide interpretation services (except upon the Member's own request).

2.6.6.3.4. The Contractor shall make Member-related materials (including, but not limited to handbook, correspondence and newsletters) available at a sixth grade reading level and comparable numeracy level and shall post all signage in all prevalent languages.

2.6.6.3.5. Communications with Members, who prefer to receive communications (oral and written) in one of the prevalent languages, shall be given in that preferred language and without burdening the Member with the need to ask for a translation.

2.6.6.4. Wraparound Benefits

2.6.6.4.1. The Contractor shall inform Members about the existence of, and how to obtain, Medicaid Wraparound Benefits.

2.6.7. Prevalent Languages

2.6.7.1.1. Spanish is the only non-English prevalent language under this agreement for the Service Area.

2.6.7.2. Alternative Formats

2.6.7.2.1.1. The Contractor shall have a mechanism to provide alternative formats of all written materials to Members. Alternative formats include large print, Braille, audio tape and other appropriate materials that take into consideration the special needs of the Member who requests information in an alternative format.

2.6.7.3. Member Handbook (Paper Version)

2.6.7.3.1. Within thirty (30) days of initial enrollment the Contractor shall distribute to each new Member a Member handbook. Annually thereafter, Contractor shall mail each Member a notice that specifies how to request a new copy of the handbook, if desired.

2.6.7.3.2. The Contractor shall notify Members by mail whenever a substantial change is made to the Member handbook.

2.6.7.4. Member Handbook (Web Version)

2.6.7.4.1. The Contractor shall make the information contained in the Member handbook available on the Contractor's web site for viewing.

2.6.7.4.2. The Contractor is encouraged to distribute the handbook electronically via email or web download in lieu of paper delivery to those Members who request it.

2.6.7.4.3. The Contractor shall evaluate the web version of the Member handbook for understandability and usefulness including font size, reading level, intuitive content organization, ease of navigation and alternative language format.

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

2.6.7.5. Provider Directory (Web Version)

2.6.7.5.1. The Contractor shall maintain a current (within thirty (30) days) Provider listing on a web site which contains the same information that is contained in the Provider directory.

2.6.7.6. Notice of Privacy Practices

2.6.7.6.1. 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 CFR 164.520.

2.6.7.6.2. The Contractor may include the notice in or with the Member handbook.

2.6.7.7. Advance Directives

2.6.7.7.1. At the time of initial enrollment, the Contractor shall provide written information to adult Members with respect to advance directives.

2.6.7.8. Distribution of Statements

2.6.7.8.1. The Contractor shall distribute statements of Members' rights and responsibilities to Members in the Member Handbook. The Contractor shall post these Statements on the web site.

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

2.6.7.9. Distribution of Practice Guidelines

2.6.7.9.1. The Contractor shall disseminate, at no cost, practice guidelines to all Members and potential Members, upon request.

2.6.7.10. Member Materials

2.6.7.10.1. The Contractor shall ensure that all Member handbooks, informational materials and instructional materials are provided in a manner and format in line with a sixth (6th) grade reading level and comparable numeracy level.

2.6.7.10.2. The Contractor shall ensure that all vital materials are translated into all prevalent languages and are available for immediate dissemination in that language.

2.6.7.10.2.1. At a minimum, vital material include notices of action, consent forms, communications requiring a response from the Member, and all grievance, appeal and requests for State fair hearing information.

2.6.7.10.3. The Contractor shall ensure that all Member handbooks, informational materials and instructional materials conform to the design and layout specifications of the publication Writing and Designing Print Materials for Beneficiaries: A Guide for State Medicaid Agencies, published by CMS.

2.6.7.10.4. The Contractor shall not misrepresent or falsify information furnished to Members or potential Members.

2.6.8. Member Rights

2.6.8.1. The Contractor shall comply with federal regulations at 42 CFR § 438.100 pertaining to Member rights, and ensure that its staff and providers take those rights into account when furnishing services to Members.

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

2.6.8.2.1. Stakeholders.

2.6.8.2.2. Providers.

2.6.8.2.3. Member's families.

2.6.8.2.4. Members.

2.6.8.2.5. Case workers.

2.6.8.3. The Contractor shall comply with the requirements outlined in the attached document entitled "Member Services."

2.6.8.4. The Contractor shall ensure that its providers and subcontractors provide information to Members and families regarding Member rights, grievances and appeals, available services, access to care standards, and other important information requested by the Department. The Contractor shall also ensure that all providers and subcontractors distribute information to Members and families regarding the role and duties of the Contractor.

2.6.9. Member Information

2.6.9.1. The Contractor shall meet the federal requirements regarding Member information as outlined in 42 CFR § 438.10 for all Member information it provides. The Contractor shall provide Member information that includes, but is not limited to:

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

2.6.9.2. 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:

2.6.9.2.1. The Child Mental Health Treatment Act (CMHTA).

2.6.9.2.2. EPSDT.

2.6.9.2.3. Community resources.

2.6.9.2.4. Member rights.

2.6.10. Ombudsman for Medicaid Managed Care

2.6.10.1. 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.

2.6.10.2. The Contractor shall share PHI, with the exception of psychotherapy notes or SUD related diagnoses or services, 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.

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

2.6.10.3.1. DELIVERABLE: Ombudsman Policy.

2.6.10.3.2. DUE: Within thirty (30) days after the Operational Start Date.

2.6.11. Website

2.6.11.1. The Contractor shall develop and maintain a customized and comprehensive website that provides on-line access to general customer service information that includes, but is not limited to:

2.6.11.1.1. Contractor’s contact information.

2.6.11.1.2. Member rights and handbooks.

2.6.11.1.3. Grievance and appeal procedures and rights.

2.6.11.1.4. General functions of the Contractor.

2.6.11.1.5. Trainings.

2.6.11.1.6. Provider directories and contact information.

2.6.11.1.7. Access to care standards.

2.6.11.2. 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).

2.6.11.3. The Contractor shall use their website in innovative ways in order to achieve greater efficiencies with providers, stakeholders, Members, and family members.

2.7. REGION SPECIFIC REQUIREMENTS

2.7.1. Integration

2.7.1.1. In addition to the requirements described in Section 2.4, the Contractor shall:

2.7.1.1.1. Implement the six (6) strategies (that align with the Vermont Blueprint for Health) to further integration efforts in its region.

2.7.1.1.2. Establish Members with a Patient-Centered Medical Home (PCMH) or the closest available alternative.

2.7.1.1.2.1. For those PCMHs with established integrated behavioral health capacity, the Contractor shall help with referrals for Members with particularly complex behavioral health care needs and/or those in need of specialty services or in-patient substance use disorder treatment.

2.7.1.1.2.2. For PCMHs with less robust integrated programs the Contractor shall:

2.7.1.1.2.2.1. Provide technical assistance to develop an integrated program for larger practices.

2.7.1.1.2.2.2. Fill in the gaps with a trained workforce including Integrated Care Managers and telehealth innovations for smaller and/or rural practices which may not be able to support the entire spectrum of on-site staff (care managers, behavioral health providers, psychiatrists, etc.).

2.7.1.1.3. Work towards helping PCMHs develop the highest level of integration possible, with the Contractor filling in with resources and technologies where the practices are not yet ready.

2.7.1.1.4. Streamline data integration with their RCCO partners by deploying a web based Member-centered plan that incorporates all information important for integrated care coordination (medical, behavioral, pharmacy, health risk assessments, wellness and crisis plans, and advanced directives) with Web-based accessibility by all treating Providers and care coordinators.

2.7.2. Members involved with the Correctional System

2.7.2.1. In addition to the requirements described in Section 2.4.2.4.2.5, the Contractor shall:

2.7.2.1.1. Implement Justice Connect.

2.7.2.1.2. Offer the correctional systems throughout the South/West Service Area access to Justice Connect as a tool for coordinating services across systems.

2.7.2.1.3. Hire a full-time Correctional Services Coordinator (CSC) as the single point of contact for working with correctional facilities.

2.7.3. Members residing in Long-Term Care/Nursing Facilities

2.7.3.1. In addition to the requirements described in Section 2.4.2.4.2.1, the Contractor shall:

2.7.3.1.1. Provide a long-term care hotline which will be linked directly to staff specializing in providing solutions to issues experienced by Members in the long-term care system, as well as problem solving for complex situations.

2.7.4. Female Medicaid Members for a period of one year Post-Partum

2.7.4.1. In addition to the requirements described in Section 2.4.2.4.2.6, the Contractor shall:

2.7.4.1.1. Provide referral information to those in contact with new mothers.

2.7.4.1.2. Make educational and outreach materials in English and Spanish available to female Members. These materials shall describe the link between psychological concerns and post-partum status, and provide contact information if there are further questions or if the Member would like an appointment for services.

2.7.4.1.3. The Contractor shall work with area agencies to provide outreach to Members who are expecting or recently have had a baby.

2.7.5. Access to Care

2.7.5.1. In addition to the requirements described in Section 2.5.8, the Contractor shall:

2.7.5.1.1. Deploy automated appointment and prescription reminders (through its Health Alerts System) and target identification of gaps in care to improve care coordination (through its Clinical Care Alerts system).

2.7.6. Service Planning

2.7.6.1. In addition to the requirements described in Section 2.5.11, the Contractor shall:

2.7.6.1.1. Implement the Mental Health-Child Welfare Learning Community.

2.7.6.1.2. Organize and offer annual live training events in at least three (3) sub-regions within its service area.

2.7.6.1.3. Offer at least four (4) web-based training programs per year for those county case workers who cannot attend one of the live training events.

2.7.6.1.3.1. Both the live and web-based training shall provide county caseworkers with an opportunity to learn about how to access behavioral health and substance use disorder services through the BHO, access to care standards, available services, the Provider Network and other topics of relevance.

2.7.6.1.4. Provide a forum to counties to address questions and concerns and to share the Contractor's foundational treatment philosophies related to trauma informed care, family-centered care and recovery and resiliency.

2.7.7. Special Populations/Special Health Care Needs

2.7.7.1. In addition to the requirements described in Section 2.4.2.4.2.4, the Contractor shall:

2.7.7.1.1. Identify all care coordinators and case managers (RCCO, primary care practice, SEP, DHS, etc.) involved in each Member's care and facilitate the designation and documentation of a single lead care manager who will "coordinate the coordinators."

2.8. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

2.8.1. For all covered services, the Contractor shall maintain an outcomes, quality assessment and performance improvement program that complies with 42 C.F.R. Section 438.200.

2.8.2. The Contractor shall monitor its providers' performances on an ongoing basis and hold them accountable to a formal review according to a periodic schedule. The formal review shall be consistent with industry standards or State MCO laws and regulations.

2.8.2.1. The Contractor may use standard sampling and problem-provider targeting to maintain and improve Provider performance.

2.8.3. The Contractor shall allow the Department or its designee to conduct surveys, reviews, and audits of providers in the Contractor's network at any time to ensure quality services are being provided to Members and contractual requirements or federal and state rules and regulations are being followed.

2.8.4. Practice Guidelines

2.8.4.1. The Contractor shall meet the requirements of this contract, federal managed care regulations (42 CFR Part 438), and 42 CFR Part 2 confidentiality regulations when adopting practice guidelines.

2.8.5. Performance Improvement Projects

2.8.5.1. The Contractor shall have a minimum of one (1) performance improvement project (PIP) chosen by the Department, and the second PIP, if done, shall be identified by the Department at a future date.

2.8.5.1.1. PIPs will be validated by the Department's external quality review organization (EQRO). The primary objective of the PIP validation is to determine compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

2.8.5.1.1.1. Measurement and intervention to achieve significant improvement, where mathematically possible, sustained over time in clinical and non-clinical

care areas expected to have a favorable effect on health outcomes and enrollee satisfaction.

2.8.5.1.1.2. Mechanisms to detect both under-utilization and over-utilization of services.

2.8.5.1.1.3. Mechanisms designed to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

2.8.5.1.1.4. Measurement of performance using objective valid and reliable quality indicators.

2.8.5.1.1.5. Implementation of system interventions to achieve improvement in quality.

2.8.5.1.1.6. Empirical evaluation of the effectiveness of the interventions.

2.8.5.2. The Contractor shall summarize the status and results of each performance improvement project in the annual quality report and when requested by the Department. The status and results of each performance improvement project shall be submitted in sufficient detail to allow the Department and/or its designee to validate the projects. The Contractor shall participate in data sharing, as well as outcomes and interventions in an annual PIP conference.

2.8.6. Performance Incentives

2.8.6.1. The Contractor shall work with the Department to develop a performance incentive program and implementation timeline based on specific performance measures included in this Contract.

2.8.6.2. The Department may have limited funds to reward Contractors for their performance. The Department may elect to not setup a performance incentive program in its sole discretion.

2.8.6. Performance Measures

2.8.6.1. The Contractor shall participate in the annual measurement and reporting of the performance measures required by the Department, with the expectation that this information will be placed in the public domain. The Contractor shall calculate additional performance measures when they are developed and required by CMS or the Department. The current required performance measures will be provided by the Department. The Contractor shall work with the Department to develop agreed-upon measurement criteria, reporting frequency and other components of this requirement.

2.8.7. RCCOs and physical health/integration efforts and outcomes

2.8.7.1. The Contractor shall submit an Integration Report on the progress of each integration strategy identified in Section 2.4.2.3. The report shall be submitted to the Department on a quarterly basis and will include:

2.8.7.1.1. Each strategy to increase the integrated care competencies of providers in the network;

2.8.7.1.2. Summary of the supporting activities and results of each strategy;

2.8.7.1.3. Updated reporting for each measurable goal, as applicable;

2.8.7.1.4. Any new strategies, efforts, and/or lessons learned related to integrated care efforts in the region.

2.8.7.2. DELIVERABLE: Integration Report.

2.8.7.3. DUE: Quarterly by September 30th, December 31st, March 31st and June 30th.

2.8.8. Colorado Client Assessment Record

2.8.8.1. The Contractor's provider network shall comply with the current Colorado Client Assessment Record (CCAR) policy which is as follows:

2.8.8.1.1. An "admission" CCAR must be completed upon a Member receiving four (4) or more service encounters during any continuous six-month period.

2.8.8.1.2. The State and the provider community have jointly developed a list of certain procedure codes that are considered "exempt" from triggering the administration of a CCAR. Receipt of these services does not count towards the total of services received within a six-month period. Procedure codes exempt from CCAR are listed in Exhibit H.

2.8.8.1.3. For providers under contract with the Office of Behavioral Health (OBH), requirement #1 above does not exempt the provider from meeting any of its OBH contract targets.

2.8.8.1.4. Providers may voluntarily administer CCARs to Members who receive fewer than four (4) service encounters.

2.8.8.2. The Contractor shall submit an electronic file of all completed CCAR tools to the Department and/or designee (e.g., Office of Behavioral Health) in a format determined by the Department or its designee. If changes to the CCAR are made, the Contractor shall implement all changes. At the Department's request, the Contractor shall participate and collect the Drug/Alcohol Coordinated Data System (DACODS) for Members with a substance use disorder diagnosis.

2.8.9. Member Satisfaction

2.8.9.1. The Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor.

2.8.9.2. Contractor shall support OBH's efforts to collect Member satisfaction data via the statewide Mental Health Statistics Improvement Program (MHSIP) and the Youth Services Surveys for Families (YSS-F).

2.8.9.2.1. The Contractor shall provide these surveys to Members with a substance use diagnosis at the direction of the Department.

2.8.9.3. Upon direction by the Department, the Contractor shall conduct a survey in collaboration with the OBH. The Department is considering the use of the ECHO 3.0 Adult and the ECHO 3.0 Child/Parent survey tool as part of this data collection effort, and should the Department decide to use those tools, the Contractor shall implement all necessary changes to its policies and procedures necessary for the use of those tools and shall use those tools as directed by the Department.

2.8.10. Quality of Care Issues

2.8.10.1. For the purpose of this section Quality of Care (QOC) concerns includes Department-raised concerns, Provider-raised concerns or Contractor-discovered concerns. Client complaints about care are not QOC concerns under this section and should be processed as grievances, unless the Department instructs otherwise.

2.8.10.2. When a QOC concern is raised, the Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following:

2.8.10.2.1. Sending an acknowledgement letter to the originator of the QOC concern.

2.8.10.2.2. Investigating the QOC issue(s).

2.8.10.2.3. Conducting follow-up with the Member to determine if the Member's immediate health care needs are being met.

2.8.10.2.4. Sending a QOC resolution letter to the originator of the QOC concern. This letter shall include, at a minimum:

2.8.10.2.4.1. Sufficient detail to foster an understanding of the QOC resolution.

2.8.10.2.4.2. A description of how the Member's health care needs have been met.

2.8.10.2.4.3. A contact name and telephone number to call for assistance or to express any unresolved concerns.

2.8.10.2.5. Referring QOC issues to the Contractor's peer review committee, when appropriate.

2.8.10.2.6. Referring or reporting the QOC issue to the appropriate regulatory agency and Child or Adult Protective Services for further research, review or action, when appropriate.

2.8.10.2.7. Notifying the appropriate regulatory or licensing board or agency when the affiliation of a mental health care professional or qualified service provider is suspended or terminated due to quality of care concerns.

2.8.10.2.8. Documenting the incident in a QOC file. This file shall include, at a minimum:

2.8.10.2.8.1. The name and contact information of the originator of the QOC concern.

2.8.10.2.8.2. A description of the QOC concern including issues, dates and involved parties.

2.8.10.2.8.3. All steps taken during the QOC investigation and resolution process.

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

2.8.10.2.8.5. Evidence of the QOC resolution.

2.8.10.2.8.6. A copy of the acknowledgement and resolution letters.

2.8.10.2.8.7. Any referral made by the Contractor to peer review, a regulatory agency or a licensing board or agency.

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

2.8.10.3. For alleged QOC concerns involving Physician Providers, the Contractor shall use the process of its professional review committee, as set forth in Section 12-36.5-104, C.R.S.

2.8.10.4. The Contractor shall submit a letter to the Department, upon request, that includes a brief description of the issue, the efforts that the Contractor took to investigate the issue and the outcome of the review.

2.8.10.4.1. The description of the outcome shall include whether the issue was found to be a QOC issue and what action the Contractor intends to take with the Provider(s) involved.

2.8.10.4.2. The letter shall not include the names of the persons conducting the investigation or participating in a peer review process.

2.8.10.4.3. If the Contractor refers the matter to a peer review process, it shall inform the Department of the referral.

2.8.10.4.4. The complete letter shall be sent to the Department 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.

2.8.10.4.4.1. DELIVERABLE: QOC Description Letter.

2.8.10.4.4.2. DUE: Within ten (10) Business Days of the Department's Request.

2.8.10.5. The Contractor shall have a system for identifying and addressing all alleged quality of care concerns, including those involving physician providers, and shall take action as necessary to address all confirmed quality of care concerns.

2.8.10.5.1. The Contractor may use the process of its professional review committee, as set forth in C.R.S. 12-36.5-104, when a quality of care concern is brought to its attention. The Contractor shall not disclose any information that is confidential by law.

2.8.10.5.2. DELIVERABLE: Quality of Care Concerns Process.

2.8.10.5.3. DUE: Within thirty (30) days following the Operational Start Date.

2.8.11. Quality Improvement Committee

2.8.11.1. The Contractor shall have its Quality Improvement Director or their designee participate in the Department's Behavioral Health Quality Improvement Committee (BQuIC), to provide input and feedback regarding quality improvement priorities, performance improvement topics, measurements and specifics of reporting formats and time frames, and other collaborative projects.

2.8.11.2. Contractor shall collaborate with the Department and the Department's EQRO vendor to implement a provider survey to support an additional quality data element.

2.8.12. Health Information Systems

2.8.12.1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to:

2.8.12.1.1. Utilization.

2.8.12.1.2. Grievances and appeals.

2.8.12.1.3. Third party liability.

2.8.12.2. The Contractor shall make all collected data available to the Department, the Department's designee and to CMS upon request.

2.8.12.2.1. DEVLIVERABLE: Health Information Data.

2.8.12.2.2. DUE: Upon Request of the Department, the Department's designee or CMS.

2.8.13. External Quality Review (EQR)

2.8.13.1. The Contractor shall participate in annual, external independent site reviews, and Performance Measure Validation in order to review compliance with Department standards and contract requirements.

2.8.13.2. External quality review activities shall be conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols.

2.8.13.3. The Contractor shall also participate in an annual 411 audit conducted by the External Quality Review Organization (EQRO) and the Department. The Contractor shall submit all data and records necessary for the performance of a 411 audit to the Department or its designee. The Department will inform the Contractor of all other steps necessary to complete the 411 audit.

2.8.14. Annual Quality Report

2.8.14.1. The Contractor shall maintain a process for evaluating the impact and effectiveness of the outcomes, quality assessment and improvement program on at least an annual basis.

2.8.14.2. The Contractor shall submit an annual report to the Department and/or designee, detailing the findings of the Program effectiveness.

2.8.14.2.1. DELIVERABLE: Annual Report.

2.8.14.2.2. DUE: Annually by September 30th.

2.8.15. Quality Improvement Plan

2.8.15.1. The Contractor shall develop and implement a quality improvement plan.

2.8.15.1.1. In the Quality Improvement Plan, the Contractor shall delineate future quality assessment and performance improvement activities based on the results of those activities in the Annual Report.

2.8.15.1.2. The Contractor shall integrate findings and opportunities for improvement identified in studies, performance outcome measurements, enrollee satisfaction surveys and other monitoring and quality activities into the Qualify Improvement Plan.

2.8.15.1.3. The Quality Improvement Plan is subject to the Department and/or designee's approval.

2.8.15.1.3.1. DELIVERABLE: Quality Improvement Plan.

2.8.15.1.3.2. DUE: Annually by September 30th.

2.9. COMPLIANCE AND MONITORING

2.9.1. The Contractor shall have a system for ensuring compliance with Program rules, requirements, and confidentiality regulations. The system shall include mechanisms for conducting utilization management, program integrity and compliance reporting activities as well as the submission of encounter data and maintenance of records. All aspects of the system shall be focused on providing high quality, medically necessary services in accordance with contract requirements.

2.9.2. Utilization Management

2.9.2.1. The Contractor shall establish and maintain a utilization management program to monitor access to and appropriate utilization of covered services. The program shall be under the direction of an appropriately qualified clinician. Utilization determinations shall be based on written criteria and guidelines developed or adopted with involvement from practicing providers or nationally recognized standards. The utilization management process shall in no way impede timely access to services.

2.9.2.2. The contractor shall comply with the UM Policies and Procedures provided by the Department. The Department may modify the UM Policies and Procedures upon thirty (30) days' notice to the Contractor unless the Department and the Contractor agree on a different time period.

2.9.3. Program Integrity

2.9.3.1. The Contractor shall have a compliance plan and administrative and management arrangements or procedures designed to prevent and detect fraud, abuse and misuse of Medicaid funds and resources.

2.9.3.1.1. The Contractor shall create a compliance program plan documenting the Contractor's written policies and procedures, standards and practices. The compliance program plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer. The compliance program plan shall be submitted to the Department for review and approval and shall include, but not be limited to:

2.9.3.1.1.1. Provisions for internal monitoring and auditing.

2.9.3.1.1.2. Provisions for response to detected offenses and for development of corrective action initiatives.

2.9.3.1.1.3. Processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.

2.9.3.1.1.4. Mechanisms to identify and report suspected instances of Medicaid fraud, waste and abuse.

2.9.3.1.1.5. Mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered and identifying inflated bills for services and/or goods provided.

2.9.3.1.1.5.1. DELIVERABLE: Compliance Program Plan.

2.9.3.1.1.5.2. DUE: Within thirty (30) days of the Operational Start Date.

2.9.3.1.2. The Contractor shall establish a process for training existing and new employees on the compliance program.

2.9.3.1.3. The Contractor shall designate a compliance officer and a compliance committee that are accountable to the Contractor's senior management.

2.9.3.1.4. The Contractor shall maintain lines of communication between the compliance officer and the Contractor's employees for reporting violations.

2.9.3.1.5. The Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.

2.9.3.2. The Contractor shall immediately report known, confirmed, intentional incidents of fraud and abuse to the Department and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU), based upon direction by the Department.

2.9.3.3. The Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department. The Contractor shall investigate its suspicions and shall submit its written findings and concerns to the Department within three (3) Business Days of the verbal report.

2.9.3.3.1. If the investigation is not complete in three (3) Business Days, the Contractor shall continue to investigate. A final report shall be submitted within fifteen (15) Business Days of the verbal report. The Department may approve an extension of time in which to complete the final report upon a showing of good cause.

2.9.3.4. At the Department's request, the Contractor shall suspend payments to any Participating Provider against whom there is a credible allegation of fraud.

2.9.3.5. The Contractor may, on its own initiative, suspend payment to any Participating Provider against whom there is a credible allegation of fraud, but only after consultation with the Department and the Medicaid Fraud Control Unit. 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.

2.9.3.6. The Department may suspend managed care capitation payments to the Contractor, in whole or in part, when the Contractor and/or any party with an ownership or control interest in the Contractor's organization is under investigation for a credible allegation of fraud.

2.9.3.6.1. Suspension of capitation payments to the Contractor may be initiated by the Department when the Contractor appears complicit in the alleged fraud, or should have, by reasonable standards, been aware of and/or reported it to the Department.

2.9.3.7. The Contractor shall submit a CPT Frequency and Methods Plan to the Department that describes how frequently, and by what method, it shall assure that Providers' CPT billing accurately reflects the level of services provided to Members so that there is no intentional or unintentional upcoding or miscoding of services. This plan shall be part of the Compliance Program Plan as noted in Section 2.9.3.1.1.5.1.

2.9.3.8. The Contractor shall submit a Member Services Verification Plan to the Department that describes methods the Contractor uses to validate Member service delivery and to ensure Members are receiving the services for which billing occurred.

2.9.3.8.1. DELIVERABLE: Member Services Verification Plan.

2.9.3.8.2. DUE: Within sixty (60) days following the operational start date

2.9.3.9. The Contractor shall comply with the requirements outlined in Section 2.10, Notices and Disclosures.

2.9.3.10. The Contractor shall notify the Department when they take adverse action against a network provider for program integrity-related reasons.

2.9.3.10.1. DELIVERABLE: Notification of Adverse Action.

2.9.3.10.2. DUE: Within three (3) Business Days of the Contractor's Action.

2.9.3.11. The Contractor shall develop and implement a Notification of Adverse Action Procedures for reporting these actions to the Department and other necessary entities.

2.9.3.11.1. DELIVERABLE: Notification of Adverse Action Procedures.

2.9.3.11.2. DUE: Within fifteen (15) days after the Operational Start Date.

2.9.3.12. The Contractor shall participate in joint meetings held by the Department and the Medicaid Fraud and Control Unit to discuss issues related to fraud, abuse, and misuse of Medicaid funds and resources.

2.9.4. Encounter Data

2.9.4.1. The Contractor shall submit an Encounter Data Report with encounter data to the Department and/or its designee on all State Plan and 1915(b)(3) Waiver (Alternative) services electronically (detailed below) in a flat-file format.

2.9.4.1.1. The Contractor shall submit a monthly flat-file to the Department.

2.9.4.1.1.1. DELIVERABLE: Encounter Data Report.

2.9.4.1.1.2. DUE: On the last day of the month following the month in which the services took place.

2.9.4.1.2. The Contractor shall submit monthly data certifications for all flat-file data utilized for the purposes of rate setting (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.

2.9.4.1.2.1. DELIVERABLE: Data Certifications.

2.9.4.1.2.2. DUE: Within 45 days following the month in which the services took place.

2.9.4.2. The Contractor is required to submit all Encounter Claims Data 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).* Encounter data shall be submitted 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 and/or adjusted by the Contractor shall be submitted via a regular monthly batch process. All encounter claims shall be submitted in accordance with the following:

2.9.4.2.1. Applicable HIPAA transaction guides posted available at: http://www.wpc-edi.com.

2.9.4.2.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

2.9.4.2.3. 837 X12N Companion Guide Specifications available at: http://www.colorado.gov/hcpf.

2.9.4.3. The Contractor shall either demonstrate or contract for knowledge and experience with the Electronic Data Interchange (EDI) of ANSI ASC X12N 837 formatted encounter data for these submittals. Detailed format information for the ANSI 837 transaction is available at www.wpc-edi.com. HIPAA companion guides to prepare systems to work with the Colorado Medicaid program and details of acceptable Colorado Program values can be found at: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218102958082. Data submission shall comply with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of a Qualified Service Organization (QSO) Agreement.

2.9.4.4. The Department reserves the right to change format requirements at any time, following consultation with the Contractor and retains the right to make the final decision regarding format submission requirements.

2.9.4.5. Contractor shall use the enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. Such data transmissions and enrollment reports shall include:

2.9.4.5.1. Medicaid Management Information System (MMIS) reports, which verify Medicaid eligibility

2.9.4.5.2. Daily generated Prepaid Health Plan (PHP) Manually Override of enrollment data changes (R0268)

2.9.4.5.3. Daily generated PHP Disenrollment Report (R0305)

2.9.4.5.4. Monthly generated PHP Disenrollment Report (M0305)

2.9.4.5.5. Monthly generated PHP Enrollment Change Report (R0310)

2.9.4.5.6. Monthly generated PHP Current Membership Report (R0315)

2.9.4.5.7. Daily generated PHP New Membership Report (R0325)

2.9.4.5.8. Monthly generated PHP New Membership Report (M0325)

2.9.4.5.9. Monthly generated PHP Capitation Summary Report (R0360)

2.9.4.5.10. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction

2.9.4.5.11. HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction.

2.9.5. Compliance Reporting

2.9.5.1. The Contractor shall have a mechanism to systematically track, monitor and report all information as summarized in the Compliance Reporting requirements shown in Section 2.11.

2.9.6. Maintenance of Records

2.9.6.1. The Contractor shall ensure that all Subcontractors and contracted providers comply with all record maintenance requirements of the Contract, as shown in Section 9 of this Contract.

2.9.7. Physician and Individual Provider Credentialing and Monitoring

2.9.7.1. Policies and Procedures

2.9.7.1.1. The Contractor shall have a process, described in written policies and procedures, to evaluate potential providers before they provide care to Members, and to reevaluate them periodically (according to NCQA credentialing standards) thereafter.

2.9.7.1.2. The Contractor shall adopt policies and procedures that describe the methods of Provider monitoring. The policies shall at a minimum describe:

2.9.7.1.2.1. The frequency of monitoring.

2.9.7.1.2.2. How providers are selected to be reviewed.

2.9.7.1.2.3. Scoring benchmarks.

2.9.7.1.2.4. The way record samples will be chosen.

2.9.7.1.2.5. How many records will be reviewed.

2.9.7.1.3. The Department encourages a survey checklist for the actual Provider visits.

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

2.9.7.1.4.1. DELIVERABLE: Provider Credentialing Policies and Procedures.

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

2.9.7.2. Credentialing and Recredentialing

2.9.7.2.1. Credentialing

2.9.7.2.1.1. The Contractor shall ensure that all individual behavioral health practitioners are credentialed.

2.9.7.2.2. Recruitment

2.9.7.2.2.1. The Contractor shall implement strategies to recruit and retain Providers that are representative of the demographic characteristics of the Service Area.

2.9.7.2.3. Standards

2.9.7.2.3.1. The Contractor shall use NCQA credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts.

2.9.7.2.3.2. 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.

2.9.7.2.4. Recredentialing

2.9.7.2.4.1. The Contractor shall ensure that recredentialing of all individual behavioral health practitioners occurs at least every three (3) years.

2.9.7.3. Eligibility

2.9.7.3.1. The Contractor shall ensure that Providers supply services only to those eligible Colorado Medicaid Clients. The Contractor shall make it the responsibility of the Provider to verify that the individual receiving behavioral health services is Medicaid eligible on the date of service, whether Contractor or the Department is responsible for reimbursement of the services provided, and whether Contractor has authorized a Referral or made special arrangements with a Provider, when appropriate.

2.9.7.4. Ongoing Periodic Monitoring at Recredentialing

2.9.7.4.1. The Contractor shall ensure that all Providers are regularly monitored and reviewed, on a periodic schedule, for compliance with requirements under this Contract and with their agreements with Contractor.

2.9.7.4.2. Cultural Competency

2.9.7.4.2.1. The Contractor shall ensure that Members receive from Providers and Provider staff effective, understandable, and respectful care that is provided in a manner compatible with Members' cultural health beliefs, practices and preferred language.

2.9.7.4.2.2. The Contractor shall ensure that all Providers and Provider staff that interact with Members receive ongoing education and training in culturally and linguistically appropriate service delivery.

2.9.7.4.2.3. The Contractor shall integrate cultural and linguistic competence-related measures into Provider audits, site reviews, credentialing and outcomes-based evaluations.

2.9.7.4.3. Medicaid Sanctions

2.9.7.4.3.1. The Contractor shall review all Providers at least annually to verify they are not subject to Medicaid sanctions.

2.9.7.4.4. Affiliations and Employment Oversight

2.9.7.4.4.1. The Contractor shall have an effective mechanism to periodically monitor impermissible affiliations and employees for the duration of the business relationship.

2.9.7.4.4.2. The Contractor shall assure that no Provider has a relationship to individuals who have been disbarred, 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 federal Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2.9.7.4.4.3. The Contractor shall assure that no Provider has a relationship to an affiliate of individuals who have been disbarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities, as defined in the Federal Acquisition Regulation.

2.9.7.4.4.4. The Contractor shall assure that no Provider have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

2.9.7.5. Periodic review of the Monitoring Program

2.9.7.5.1. The Contractor shall periodically (at least bi-annually) evaluate the effectiveness of the Provider monitoring program.

2.9.8. Other Monitoring Activities

2.9.8.1. In consultation with the Department, the Contractor shall participate in and respond to other Department and/or designee compliance monitoring activities, including but not limited to:

2.9.8.1.1. Encounter Data analysis; Encounter Data validation (the comparison of Encounter Data with Medical Records;

2.9.8.1.2. Appeals analysis to identify trends in the Community Mental Health Services Program and among behavioral health care organizations; and,

2.9.8.1.3. Other reviews determined by the Department.

2.9.9. Inspection, Monitoring and Site Reviews

2.9.9.1. Contractor shall make staff available to assist in any audit or inspection under the Contract.

2.9.9.2. Contractor shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting all audits, site reviews or inspections.

2.9.9.3. Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

2.9.9.4. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

2.9.10. Site Reviews

2.9.10.1. In addition to the requirements of this Contract, the Contractor shall allow the Department or its designee to conduct site reviews at least annually, or more frequently as determined by the Department.

2.9.10.1.1. 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.

2.9.10.2. The Contractor shall allow the Department or its designee to conduct an emergency or unannounced review for instances including but not limited to Member safety, quality of care, potential fraud, or financial viability.

2.9.10.3. 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. 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.

2.9.10.4. The Contractor shall make available to the Department and/or designee and its agents for site review all records and documents related to the Contract, either on a scheduled basis, or immediately on an emergency or unannounced basis.

2.9.10.5. The Contractor shall respond to any required actions with a corrective action plan within thirty (30) calendar days of the final report, specifying the action to be taken and time frames.

2.9.10.5.1. The corrective action plan shall be submitted to the Department, and is subject to approval by the Department.

2.9.10.5.2. Upon review of the proposed corrective action plan, the Department may require changes to the plan. The Contractor shall make all changes to the plan as required by the Department and resubmit the plan for the Department's approval.

2.9.10.5.3. Once the Department has approved the corrective action plan, the contractor shall implement the plan and the Contractor shall continue to progress via the corrective action plan until the Contractor is found to be in complete compliance by the Department.

2.9.10.5.3.1. DELIVERABLE: Corrective Action Plan.

2.9.10.5.3.2. DUE: Within thirty (30) calendar days of receiving the final report.

2.9.10.6. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during corrective action periods.

2.9.10.7. Site reviews may also include an inspection of Participating Providers in the Contractor's network to ensure that Providers have been educated and monitored by Contractor about the requirements under this Contract, federal and state regulations, and to ensure quality services are being provided to Members. In the event that the Site Reviewers wish to inspect a Provider location, Contractor shall assure that:

2.9.10.7.1. Providers make staff available to assist in the audit or inspection effort.

2.9.10.7.2. Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

2.9.10.8. Financial Records

2.9.10.8.1. The Contractor shall submit annual financial reports to the Department or its designee including but not limited to audited financial statements.

2.9.10.8.2. The Contractor shall submit financial reports and information as requested by the Department or its designee.

2.9.10.8.3. The Contractor shall submit information about financial arrangements with providers in their network to the Department or its designee.

2.10. NOTICES AND DISCLOSURES

2.10.1. Actions Involving Licenses, Certifications, Approvals and Permits

2.10.1.1. The Contractor shall notify the Department, within two (2) Business Days, of:

2.10.1.1.1. 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.

2.10.1.1.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

2.10.1.1.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

2.10.1.1.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits.

2.10.1.1.3.2. DELIVERABLE: Within two (2) Business Days of Contractor's notification.

2.10.2. Business Transactions

2.10.2.1. The Contractor shall, within five (5) Business Days, disclose to the Department the following business transactions:

2.10.2.1.1. Any sale, exchange or lease of any property between Contractor and a party in interest.

2.10.2.1.2. Any lending of money or other extension of credit between Contractor and a party in interest.

2.10.2.1.3. Any exchange of goods, services (including management services) or facilities between Contractor and a party in interest other than salaries paid to employees for services provided in the normal course of the employment.

2.10.2.1.3.1. DELIVERABLE: Business Transaction Notification.

2.10.2.1.3.2. DUE: Within five (5) Business Days of transaction.

2.10.2.2. Party in interest includes, but is not limited to:

2.10.2.2.1. Any director, officer, partner, or employee responsible for management or administration of Contractor; or the spouse, child, or parent of such person.

2.10.2.2.2. Any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of Contractor; or the spouse, child, or parent of such person.

2.10.2.2.3. Any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of Contractor; or the spouse, child, or parent of such person.

2.10.2.2.4. Any incorporator or member of Contractor's board; or the spouse, child, or parent of such person.

2.10.2.2.5. Any organization with directors, officers or partners (including their respective spouses, children, or parents),who are also directors, officers, partners or managing employees of Contractor or who are the spouses, children or parents of Contractor's directors, officers, partners or managing employees.

2.10.2.2.6. Any organization with directors, officers or partners (including their respective spouses, children, or parents) who have, directly or indirectly, a beneficial interest of more than five percent (5%) in the equity of Contractor.

2.10.2.2.7. Any organization with an owner (including the owner's spouse, children, or parents) who also has, directly or indirectly, a beneficial interest of more than five percent (5%) in the equity of Contractor.

2.10.2.2.8. Any organization with an owner (including the owner's spouse, children, or parents) who is also a director, officer, partner or managing employee of Contractor or who are the spouses, children or parents of Contractor's directors, officers, partners or managing employees.

2.10.2.2.9. Any organization with a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of Contractor.

2.10.2.2.10. Any person directly or indirectly controlling, controlled by, or under common control with Contractor; or the spouse, child, or parent of such person.

2.10.3. Conflict of Interest

2.10.3.1. Notice of a conflict

2.10.3.1.1. 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.

2.10.3.1.1.1. DELIVERABLE: Conflict of Interest Disclosure Statement.

2.10.3.1.1.2. DUE: Within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.

2.10.3.2. Conflict of interest defined

2.10.3.2.1. The term "conflict of interest" means that:

2.10.3.2.1.1. The Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

2.10.3.2.1.2. The relationship between the third party and the Department is such that one parties' interests could only be advanced at the expense of the others'.

2.10.3.2.1.3. A conflict of interest exists even if the Contractor does not use information obtained from one party in its dealings with the other.

2.10.4. Network Changes and Deficiencies

2.10.4.1. The Contractor shall notify the Department, in writing, within five (5) Business Days of Contractor's knowledge of an expected, 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:

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

2.10.4.1.2. Availability, or capacity of covered services.

2.10.4.1.3. A plan to minimize disruption to the Member care and service delivery.

2.10.4.1.4. A plan for clinical team meetings with the affected Member's to discuss the available options and to revise the service plan to address any changes in services or service providers.

2.10.4.1.5. A plan to correct any network deficiency.

2.10.4.2. DELIVERABLE: Network Change and Deficiency Notification.

2.10.4.3. DUE: Within five (5) Business Days of Contractor becoming aware of the change or deficiency.

2.10.5. Ownership

2.10.5.1. The Contractor shall disclose to the Department, at the time of contracting, at Contract renewal and at any time there is a change in ownership, the following information in a form to be provided by the Department:

2.10.5.1.1. The name and address of each person, including directors, managing employees, officers, partners, owners, employees or contractors with an ownership or control interest in Contractor or in any Subcontractor in which the Contractor has direct or indirect ownership of five percent (5%) or more.

2.10.5.1.2. Whether any of the persons named is related to another as spouse, parent, child, or sibling.

2.10.5.1.3. The name of any other disclosing entity in which a person with an ownership or control interest in the Contractor also has an ownership or control interest.

2.10.5.2. This requirement applies to the extent that the Contractor can obtain this information by requesting it in writing from the person.

2.10.5.3. Any Contractor that is subject to periodic survey and certification of its compliance with Medicaid standards shall supply the information specified above to the Department or its survey agency at the time it is surveyed. The Department or its survey agency shall promptly furnish the information to the Secretary of Health and Human Services and the Department.

2.10.5.4. Any Contractor that is not subject to periodic survey and certification and has not supplied the information specified above to the Secretary of Health and Human Services within the prior twelve (12) month period shall submit the information to the Department before entering into a Contract or agreement with the Department. The Department shall promptly furnish the information to the Secretary of Health and Human Services.

2.10.5.5. The Contractor shall submit updated information to the Secretary of Health and Human Services, the Department or its survey agency at intervals between Contract renewals, within thirty-five (35) calendar days of a written request.

2.10.5.5.1. DELIVERABLE: Updated Ownership Information.

2.10.5.5.2. DUE: Within thirty-five (35) calendar days of a written request of the Department.

2.10.6. Physician Incentive Plans

2.10.6.1. 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.

2.10.6.1.1. 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.

2.10.7. Policies and Procedures

2.10.7.1. The Contractor shall disclose to the Department copies of any existing policies and procedures related to Section 2.10 of this Contract, upon request by the Department, within ten (10) Business Days.

2.10.7.1.1. DELIVERABLE: Notices and Disclosures Policies and Procedures.

2.10.7.1.2. DUE: Within ten (10) Business Days of the Department's request.

2.10.8. Practice Guidelines

2.10.8.1. The Contractor shall provide practice guidelines to the Department upon request within ten (10) Business Days, and at no cost to the Department.

2.10.8.1.1. DELIVERABLE: Practice Guidelines.

2.10.8.1.2. DUE: Within ten (10) Business Days of the Department's request.

2.10.9. Relationship to Community Mental Health Centers

2.10.9.1. The Contractor shall disclose to the Department at the at the time of contracting, at Contract renewal, and at any time there is a change, the nature and extent of its financial and organizational relationship with the Community Mental Health Centers in its service region.

2.10.10. Security Breaches and HIPAA violations

2.10.10.1. 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.

2.10.10.2. Contractor shall report all HIPAA violations as described in the HIPAA BUSINESS ASSOCIATE ADDENDUM.

2.10.10.2.1. DELIVERABLE: Security and HIPAA Violation Breach Notification.

2.10.10.2.2. DUE: Within five (5) business days of becoming aware of the breach.

2.10.11. Solvency

2.10.11.1. The Contractor shall notify the Department, within 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.

2.10.11.1.1. DELIVERABLE: Solvency Notification.

2.10.11.1.2. DUE: Within two (2) Business Days, of becoming aware of a possible solvency issue.

2.10.12. Subcontracts and Contracts

2.10.12.1. 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.

2.10.12.1.1. DELIVERABLE: Subcontracts and Provider Contracts.

2.10.12.1.2. DUE: Within five (5) Business Days of the Department's Request.

2.10.12.2. The Contractor shall notify the Department, in writing, of its decision to terminate any existing subcontractor at least sixty (60) calendar days prior to the services terminating, unless the basis for termination is for quality or performance issues, or credible allegation of fraud.

2.10.12.2.1. If the basis for termination is quality or performance issue, the Contractor shall notify the Department in writing within two (2) Business Days of its decision to terminate the subcontract. Contractor shall submit, with the notice of

termination, a narrative describing how it intends to provide or secure the services after termination.

2.10.12.2.1.1. DELIVERABLE: Notice of Subcontractor Termination.

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

2.10.13. Warranties and certifications

2.10.13.1. 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.

2.10.13.1.1. DELIVERABLE: Warranty and Certification Notification.

2.10.13.1.2. DUE: Within five (5) Business Days of becoming aware of its inability to offer the warranty and certifications.

2.11. REPORTING

2.11.1. Program Compliance Reporting

2.11.1.1. Access to Services Reports

2.11.1.1.1. The Contractor shall submit a quarterly report in electronic format to the Department and/or its designee, documenting the percentage of cases meeting standards for access to routine care, urgent care, and emergency care during the given quarter. The Contractor shall submit this report in a format approved by the Department.

2.11.1.1.2. The Contractor's reports shall include detail regarding cases in which the standard was not met.

2.11.1.1.2.1. DELIVERABLE: Access to Services Report.

2.11.1.1.2.2. DUE: Thirty (30) days after the end of the reporting quarter.

2.11.1.2. 1915(b)(3) Waiver (Alternative) Services Report

2.11.1.2.1. The Contractor shall submit a quarterly report in electronic format, approved by the Department, to the Department and/or its designee detailing the previous quarter's expenditures for 1915(b)(3) Waiver (Alternative Services). Expenditure reports shall detail the specific types of services and the expenditure amounts associated with that service for the given quarter.

2.11.1.2.1.1. DELIVERABLE: 1915(b)(3) Waiver (Alternative) Services Report

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

2.11.1.2.2. Non-State Plan Services Expenditures Report

2.11.1.2.2.1. The Contractor shall submit a separate quarterly report in the same format to the Department and/or its designee detailing the previous quarter's expenditures for "Non-State Plan" services provided to AwDC (1115 demonstration) enrollees.

2.11.1.2.2.2. DELIVERABLE: Non-State Plan Services Expenditures Report

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

2.11.1.3. Annual Quality Report

2.11.1.3.1. The Contractor shall submit an annual report to the Department and/or its designee. The report shall include:

2.11.1.3.1.1. A description of the techniques used by the Contractor to improve its performance, effectiveness and quality outcomes. This report shall describe the qualitative and quantitative impact the techniques had on quality and the overall impact and effectiveness of the quality assessment and improvement program.

2.11.1.3.1.2. A description of past quality assessments and performance improvement activities targeted at creating substantial improvements in the quality and results for the next year.

2.11.1.3.1.3. A description and organizational chart for each quality committee.

2.11.1.3.1.4. Sufficient detail for the EQRO to validate the Contractor's performance improvement projects according to 42 C.F.R. Parts 433 and 438, External Quality Review of Medicaid Managed Care Organizations.

2.11.1.3.1.4.1. DELIVERABLE: Annual Quality Report

2.11.1.3.1.4.2. DUE: Annually by the last Business Day of September for the preceding fiscal year's quality activities.

2.11.1.4. Quality Improvement Plan

2.11.1.4.1. The Contractor shall submit an annual quality improvement plan to the Department and/or its designee, for approval, that delineates future quality assessment and performance improvement activities based on the results of those activities included in the Annual Quality Report.

2.11.1.4.2. The Contractor shall integrate findings and opportunities for improvement identified in studies, performance outcome measurements, Member satisfaction surveys and other monitoring and quality activities.

2.11.1.4.2.1. DELIVERABLE: Quality Improvement Plan.

2.11.1.4.2.2. DUE: Annually, no later than the last Business Day of September of each contract year.

2.11.1.5. Colorado Client Assessment Record (CCAR)

2.11.1.5.1. The Contractor shall submit CCAR data to the Division of Behavioral Health on a quarterly basis.

2.11.1.5.1.1. DELIVERABLE: Colorado Client Assessment Record (CCAR) Data.

2.11.1.5.1.2. DUE: Quarterly by September 30th, December 31st, March 31st and June 30th.

2.11.1.6. Child Mental Health Treatment Act (CMHTA) Report

2.11.1.6.1. The Contractor shall submit to the Department an annual report of all children/youth authorized for placement in a residential treatment setting by the Contractor under the CMHTA.

2.11.1.6.1.1. DELIVERABLE: Child Mental Health Treatment Act (CMHTA) Report.

2.11.1.6.1.2. DUE: Annually on September 1st.

2.11.1.7. Member Grievance and Appeals Report

2.11.1.7.1. The Contractor shall submit a Grievance and Appeals report quarterly that records, tracks, and assesses Members' grievances and appeals and their resolutions.

2.11.1.7.2. The Contractor shall analyze, investigate and report upon significant individual cases and upon overall trends.

2.11.1.7.3. Upon request of the Department, Contractor shall also report upon individual cases.

2.11.1.7.3.1. DELIVERABLE: Member Grievance and Appeals Report.

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

2.11.1.8. Network Adequacy Report

2.11.1.8.1. The Contractor shall submit a quarterly Network Adequacy report. The report shall contain the total number of Providers by type of provider, county and the number of Providers who are accepting new Clients.

2.11.1.8.1.1. DELIVERABLE: Quarterly Network Adequacy Report.

2.11.1.8.1.2. DUE: Thirty (30) days after the end of the reporting quarter.

2.11.1.8.2. Contractor shall annually conduct a needs assessment to identify unmet service needs in its service delivery area. The needs assessment shall be completed at least sixty (60) calendar days prior to the end of the contract year.

2.11.1.8.3. Thirty (30) calendar days prior to the end of the contract year, Contractor shall submit to the Department a copy of its need assessment report and shall provide written assurance that Contractor’s Network is adequate in number, mix and geographic distribution and in accordance with Department standards, for the expected level of Membership in the Service Area for the following year.

2.11.1.8.3.1. DELIVERABLE: Need Assessment and Network Adequacy Report.

2.11.1.8.3.2. DUE: Thirty (30) calendar days prior to the end of the contract year.

2.11.1.8.4. If the needs assessment report indicates that the network is not adequate to meet the population of the Contractor’s service area or if the Department determines that the network is not adequate, the Contractor shall submit an action plan outlining how and when the unmet needs will be addressed. Action plans are subject to Departmental review and approval.

2.11.1.8.4.1. DELIVERABLE: Adequacy Action Plan.

2.11.1.8.4.2. DUE: Thirty (30) calendar days prior to the end of the contract year.

2.11.1.8.5. The Contractor shall submit, within 30 days, a Network Composition Report when a new population is enrolled in Contractor's Plan, when new services are added to the contract, and/or when requested by the Department.

2.11.1.8.5.1. DELIVERABLE: Network Composition Report.

2.11.1.8.5.2. DUE: Within thirty (30) days of new enrollment or upon Department request.

2.11.1.9. Third Party Identification Report

2.11.1.9.1. Contractor shall submit a monthly report notifying the Department and the Department's fiscal agent of any third party payers, excluding Medicare, identified by the Contractor as being actually or potentially liable for some or all of the costs of Covered Services to Members.

2.11.1.9.2. For each Member identified as having other health insurance coverage, exclusive of Medicare, the report shall include:

2.11.1.9.2.1. Member's Medicaid identification number.

2.11.1.9.2.2. Member's social security number.

2.11.1.9.2.3. Member's relationship to policyholder.

2.11.1.9.2.4. Name, complete address, and telephone number of health insurer.

2.11.1.9.2.5. Policy Member identification and group numbers.

2.11.1.9.2.6. Policy Member's social security number.

2.11.1.9.2.7. Policy Member's full name, complete address and telephone number.

2.11.1.9.2.8. Daytime telephone number where the Member can be reached.

2.11.1.9.3. If Contractor identifies a Member with Medicare, the report shall contain the Member's name and Medicaid identification along with the Medicare identification number.

2.11.1.9.4. If Contractor identifies a Member with other forms of recovery potential (e.g. workers' compensation, motor vehicle accident insurance coverage, personal injury tort) the Contractor shall submit all known information regarding the circumstances giving rise to the recovery potential and the identification of the other parties and payers who may be liable.

2.11.1.9.4.1. DELIVERABLE: Third Party Identification Report.

2.11.1.9.4.2. DUE: Within ten (10) Business Days following the reporting month.

2.11.1.10. Compliance Program Plan

2.11.1.10.1. Contractor shall submit its Compliance Program Plan for approval upon each contract renewal.

2.11.1.10.1.1. DELIVERABLE: Compliance Program Plan.

2.11.1.10.1.2. DUE: Annually, no later than June 30th.

2.11.1.11. Compliance with False Claims Act

2.11.1.11.1. The Contractor shall submit its written policies that conform to the requirements detailed in Section 2.9.3, Program Integrity and detailing its compliance with:

2.11.1.11.1.1. The False Claims Act, 31 USC §§ 3729, et seq.

2.11.1.11.1.2. Administrative remedies for false claims and statements.

2.11.1.11.1.3. State laws relating to civil or criminal penalties for false claims and statements, if any.

2.11.1.11.1.4. Whistleblower protections under such laws.

2.11.1.11.1.4.1. DELIVERABLE: False Claims Policies.

2.11.1.11.1.4.2. DUE: Within forty-five (45) days after the Effective Date.

2.11.1.11.2. The Contractor shall submit, written assurance of compliance with the False Claims Act to the Department's Program Integrity Section.

2.11.1.11.2.1. DELIVERABLE: Assurance of Compliance.

2.11.1.11.2.2. DUE: Annually, within thirty (30) days of written notification by the Department's Program Integrity Section.

2.11.1.12. Graduate Medical Education Report

2.11.1.12.1. The Contractor shall submit a quarterly report detailing the total inpatient hospital days, total outpatient charges, and total inpatient discharges, by hospital, for Members for each calendar year quarter.

2.11.1.12.1.1. DELIVERABLE: Graduate Medical Education Report.

2.11.1.12.1.2. DUE: No later than ninety (90) calendar days following the end of the reporting quarter.

2.11.1.13. Performance Measures

2.11.1.13.1. The Contractor shall report annually on performance measures outlined in Exhibit G. Implementation of core performance measures shall begin upon implementation of this Contract.

2.11.1.13.2. Additional performance measures may be implemented and reported on in future Contract years, by agreement between the Contractor and the Department.

2.11.1.13.2.1. DELIVERABLE: Performance Measures Report.

2.11.1.13.2.2. DUE: Annually as requested by the Department

2.11.1.14. Third Party Recovery Report

2.11.1.14.1. The Contractor shall submit an annual report of all amounts actually recovered from third parties. The report shall contain the Medicaid Client ID, category of assistance and dates of service related to the recovery. The report shall be provided on compact disc or by encrypted email.

2.11.1.14.1.1. DELIVERABLE: Third Party Recovery Report.

2.11.1.14.1.2. DUE: Annually, no later than March 31st for the preceding fiscal year.

2.11.1.15. Annual Training Report

2.11.1.15.1. At the end of each calendar year, the Contractor shall create an Annual Training Report detailing trainings that were provided by the Contractor to its Providers, state agencies, and counties during the previous calendar year.

2.11.1.15.2. This report shall be in a format mutually agreed upon by the Department and the Contractor. This report shall detail trainings related to the requirements, policies, and procedures related to this Contract, including but not limited to, access to care, care coordination, services available to clients, member transitions, the Child Mental Health Treatment Act (CMHTA), member rights (appeals and grievances).

2.11.1.15.2.1. DELIVERABLE: Annual Training Report.

2.11.1.15.2.2. DUE: Annually on January 30th.

2.11.1.16. Integrated Care Report

2.11.1.16.1. The Contractor shall collaborate with the Regional Care Collaborative Organization (RCCO) on a semi-annual report regarding integrated care efforts in its region. The Department shall provide a standardized template for this report. The report is due from the RCCO 30 calendar days following each reporting period.

2.11.1.17. Health Insurance Providers Fee Reporting

2.11.1.17.1. In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 CFR Part 57 and required to file a form 8963, then the Contractor shall create a Health Insurance Providers Fee Report to the Department that contains all of the following information:

2.11.1.17.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).

2.11.1.17.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was $0.00.

2.11.1.17.1.3. An allocation of the fee attributable to the Work under this Contract.

2.11.1.17.1.4. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.

2.11.1.17.2. 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.

2.11.1.17.2.1. DELIVERABLE: Health Insurance Providers Fee Report

2.11.1.17.2.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963

2.11.1.18. Ad Hoc Compliance Reports

2.11.1.18.1. Upon request of the Department, the Contractor shall create ad hoc reports for compliance purposes. The Contractor may also be asked to collaborate with other State contractors (e.g. Regional Care Collaborative Organizations) on reporting deliverables.

2.11.1.18.1.1. DELIVERABLE: Ad Hoc Compliance Reports.

2.11.1.18.1.2. DUE: Within fifteen (15) days of the Department's request.

2.11.2. Institutional Compliance Reporting

2.11.2.1. Employments and Affiliations Report

2.11.2.1.1. The Contractor shall submit, annually, upon contract renewal an Employments and Affiliations Report that shall include:

2.11.2.1.1.1. The names and addresses of each person with an ownership or control interest in Contractor.

2.11.2.1.1.2. The identity of each subcontractor that provides material and significant items or services to the Contractor, and whether the subcontractor is owned, in whole or in part, directly or indirectly, by any directors, officers, partners, owners, or employees of Contractor. The disclosure shall identify the ownership person and contain a description of the magnitude of the beneficial ownership interest. An indirect ownership interest shall be established by the ownership of a spouse, parent, child, or sibling of a director, officer, partner, owner or employee of Contractor.

2.11.2.1.1.3. The identity of each subcontractor that provides material and significant items and services to Contractor, and whether the subcontractor is controlled, in whole or in part, directly or indirectly, by any directors, officers, partners, owners, or employees of Contractor. The disclosure shall identify the person with control and contain a description of the kind of control interest. An indirect control interest shall be established by the control exercised by a spouse, parent, child, or sibling of a director, officer, partner, owner or employee of Contractor.

2.11.2.1.1.4. The identity of the directors, officers, partners, owners, employees and contractors who have, and who have not, been surveyed in the prior twelve (12) months about their relationships to individuals who have been disbarred, 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 federal Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Upon Department request, survey documentation shall be copied and delivered to the Department.

2.11.2.1.1.5. The identity of any directors, managing employees, officers, partners, owners, employees or contractors who have an ownership or control interest in Contractor and who have been convicted of a criminal offense related to

that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

2.11.2.1.2. DELIVERABLE: Employments and Affiliations Report.

2.11.2.1.3. DUE: Annually, on July 1st.

2.11.2.2. Insurance Report

2.11.2.2.1. The Contractor shall submit documentation upon request by the Department establishing current and continuous insurance coverage.

2.11.2.2.2. The Department reserves the right to require complete, certified copies of all insurance policies required by this Agreement at any time.

2.11.2.2.2.1. DELIVERABLE: Insurance Report.

2.11.2.2.2.2. DUE: Within five (5) Business Days of request by the Department

2.11.2.3. Actuarial Solvency Report

2.11.2.3.1. Contractor shall submit an opinion by a qualified actuary that attests that Contractor's surplus level and outstanding claims liability meet the requirements of this Contract. Reports shall be completed in accordance with professional accounting standards and include supplementary schedules as specified by the Department.

2.11.2.3.1.1. DELIVERABLE: Actuarial Solvency Report.

2.11.2.3.1.2. DUE: Annually, no later than December 31st.

2.11.2.3.2. The Contractor shall submit to the Department financial reports for the previous fiscal year, produced in accordance with the Mental Health Accounting and Auditing Guidelines, and audited by an independent Certified Public Accountant.

2.11.2.3.2.1. DELIVERABLE: Financial Report.

2.11.2.3.2.2. DUE: Annually, no later than April 1st.

2.11.2.4. Personnel and Committee Report

2.11.2.4.1. The Contractor shall submit a report at the request of the Department identifying the following individuals:

2.11.2.4.1.1. Privacy Officer

2.11.2.4.1.2. Security Officer

2.11.2.4.1.3. Compliance Officer

2.11.2.4.1.4. QI Committee Members

2.11.2.4.1.5. Credentialing Committee Members

2.11.2.4.2. At the request of the Department the Contractor shall also submit the training, education and credentials of these individuals.

2.11.2.4.2.1. DELIVERABLE: Personnel and Committee Report.

2.11.2.4.2.2. DUE: Within five (5) days of request by the Department

2.11.2.5. Security Events Report

2.11.2.5.1. The Contractor shall submit, quarterly, a report focusing on the following four (4) primary potential risk areas:

2.11.2.5.1.1. Unauthorized systems access.

2.11.2.5.1.2. Compromised data.

2.11.2.5.1.3. Loss of data integrity.

2.11.2.5.1.4. Inability to transmit or process data.

2.11.2.5.2. Upon discovery, the Contractor shall disclose any and all incidents falling into the categories listed above, shall document its internal review of these incidents, and shall provide to the Department its corrective actions and other mitigating measures.

2.11.2.5.2.1. DELIVERABLE: Security Events Report

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

2.11.2.6. General

2.11.2.6.1. The Contractor shall inform the Department, within five (5) Business Days, of any significant event or change in circumstances that might beneficially or adversely affect Members, Providers, the Department or other stakeholders.

2.11.2.6.1.1. DUE: Significant Event/Circumstance Report.

2.11.2.6.1.2. DUE: Within five (5) Business Days of the event.

SECTION 3.0 CONTRACTOR'S GENERAL REQUIREMENTS

3.1. GENERAL REQUIREMENTS

3.1.1. 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 not disclose it to any third party without the written consent of the Department.

3.1.2. 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.

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

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

3.2. KEY PERSONNEL REQUIREMENTS

3.2.1. The Contractor shall designate people to hold the Key Personnel positions as specified in this Contract. The Contractor shall not allow for any individual to fill more than one of the roles defined as Key Personnel unless the Department has granted approval. Key personnel (unless otherwise stated) must be primarily located or stationed in Colorado for the duration of this Contract.

3.2.2. 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. 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.

3.2.3. The Contractor's Key Personnel and other operational staff shall be available for all regularly scheduled meetings between the Contractor and the Department, unless the Department has granted prior, written approval otherwise.

3.2.4. The Contractor shall ensure that the personnel and staff 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.

3.2.5. At the Department's direction, the Contractor shall make its Key Personnel and other personnel assigned to the Contract available to attend meetings as subject matter experts with stakeholders both within the State government and external or private stakeholders.

3.2.6. All of the Contractor's 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.

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

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

3.2.9. 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.

3.2.9.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change

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

3.2.10. The Key Personnel identified for this Contract are:

3.2.10.1. Executive Director or Chief Executive Officer

3.2.10.2. Chief Financial Officer

3.2.10.3. Chief Medical Director/Officer

3.2.10.4. Clinical Substance Use Disorder Coordinator. The Clinical Substance Use Disorder Coordinator shall:

3.2.10.4.1. Be knowledgeable regarding Substance Use Disorder diagnoses, services, supports, and treatments.

3.2.10.4.2. Be knowledgeable on providing care coordination and recovery approaches for Substance Use Disorder Members.

3.2.10.5. Director of Utilization Management

3.2.10.6. Member and Family Affairs Director

3.2.10.7. Outcomes or Quality Improvement Director

3.3. OTHER PERSONNEL REQUIREMENTS

3.3.1.1. The Contractor shall provide Other Personnel, individuals in addition to Key Personnel, to ensure Contractor's ability to complete the Work (Subcontractors or providers in the Contractor's network are not included in this category).

3.3.1.2. Contractor shall use its discretion to determine all Other Personnel it will require to complete the Work.

3.3.1.3. The Contractor shall ensure that the Other Personnel have previous experience, education and/or training that demonstrate that they are qualified for the positions on this project to which they will be assigned.

3.3.2. Subcontractors

3.3.2.1. The Contractor may subcontract to complete a portion of the Work required by the Contract. The conditions for using a Subcontractor or Subcontractors are as follows:

3.3.2.2. The Contractor shall not subcontract more than forty percent (40%) of the Work. Providers in the Contractor's network providing behavioral health services to Members are not considered Subcontractors.

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

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

3.3.2.3.2. DUE: The later of thirty (30) days prior to the Subcontractor beginning work or the Effective Date.

3.3.2.4. The Contractor shall obtain prior consent and written approval for any change in the use of Subcontractor(s).

3.4. DELIVERABLES

3.4.1. All deliverables shall meet Department-approved format and content requirements. The Department will specify the number of copies and media for each deliverable. The Contractor shall make all changes to deliverables as directed by the Department.

3.4.2. Each deliverable will follow the deliverable submission process as follows:

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

3.4.2.2. 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.

3.4.2.2.1. 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.

3.4.2.2.2. 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.

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

3.4.3. 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, organized into a logical order, contain no spelling or grammatical errors, 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.

3.4.4. At the Department's request, the Contractor shall be required to conduct a walk-through of Department-selected deliverables to facilitate the Department's review process. The walk-through shall consist of an overview of the deliverable, explanation of the organization of the deliverable, presentation of critical issues related to the deliverable and other information as requested by the Department. It is anticipated that the content of the walk-through may vary with the deliverable presented.

3.4.5. 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.

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

3.4.7. 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.

3.4.8. 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.

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

3.4.9. Any document, report, deliverable or other item delivered to the Department for review and approval shall require written approval by the Department before the Contractor may consider that document, report, deliverable or other item approved and complete. Written approval by the Department may be delivered via electronic mail (email) to the Contractor.

3.5. STATED DELIVERABLES AND PERFORMANCE STANDARDS

3.5.1. 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.

3.6. COMMUNICATION REQUIREMENTS

3.6.1. Communication with the Department

3.6.1.1. 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.

3.6.2. Communication with Clients, Providers and Other Entities

3.6.2.1. The Contractor shall create a Communication Plan that includes, but is not limited to, all of the following:

3.6.2.1.1. A description of how the Contractor will communicate to Clients any changes to the services those Clients will receive or how those Clients will receive the services.

3.6.2.1.2. A description of the communication methods, including things such as email lists, newsletters and other methods, the Contractor will use to communicate with Providers and Subcontractors.

3.6.2.1.3. The specific means of immediate communication with Clients and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

3.6.2.1.4. 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 Clients or Providers are insufficient.

3.6.2.1.5. A listing of the following individuals within the Contractor's organization, that includes cell phone numbers and email addresses:

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

3.6.2.1.5.2. An individual who is responsible for any website or marketing related to the Work.

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

3.6.2.2. The Contractor shall deliver the Communication Plan to the Department on a template provided by the Department or Contractor. The template is subject to approval by the Department.

3.6.2.2.1. DELIVERABLE: Communication Plan

3.6.2.2.2. DUE: Within sixty (60) Business Days after the Effective Date or longer if approved by the Department.

3.6.2.3. 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.

3.6.2.3.1. DELIVERABLE: Annual Communication Plan Update

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

3.6.2.4. 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.

3.6.2.4.1. DELIVERABLE: Interim Communication Plan Update

3.6.2.4.2. 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

3.7. BUSINESS CONTINUITY

3.7.1. 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:

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

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

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

3.7.1.3. How the Contractor will minimize the effects on Members in the event of a Business Interruption or disaster.

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

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

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

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

3.7.2.1. DELIVERABLE: Business Continuity Plan.

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

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

3.7.3.1. DELIVERABLE: Updated Business Continuity Plan

3.7.3.2. DUE: Semi-annually, by June 30th and December 31st of each year

3.7.4. In the event of any Business Interruption, the Contractor shall implement its most recently approved Business Continuity Plan or Updated Business Continuity Plan immediately after the Contractor becomes aware of the Business Interruption. In that

event, the Contractor shall comply with all requirements, deliverables and milestones contained in the implemented plan.

3.8. FEDERAL FINANCIAL PARTICIPATION RELATED INTELLECTUAL PROPERTY OWNERSHIP

3.8.1. 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.

3.8.2. To facilitate obtaining the desired amount of federal financial participation under 42 CFR §433.112, the Department shall have all ownership rights, not superseded by other licensing restrictions, in all materials, programs, procedures, designed, purchased, or developed by the Contractor and primarily funded by the Department specifically and solely to perform the Work. "Primarily funded" in this context shall mean fifty-one percent (51%) or more of the funding to design, purchase or develop such materials, programs or procedures. Proprietary materials, programs, procedures, etc., that were not designed, purchased, or developed by the Contractor specifically and solely to perform the Work, and not primarily funded by the Department specifically and soley to perform the Work, even if used to perform the Work, remain the property of the Contractor. The Contractor shall use contract funds to develop all necessary materials, programs, products, procedures, etc., and data and software to specifically fulfill its obligations under the Contract. Department funding used in the development of these materials, programs, procedures, etc. specifically and solely to perform the Work 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 specifically and solely designed and developed to produce any systems, programs reports and documentation and all other work products or documents created under the Contract. Data and software, or modifications thereof and associated documentations and procedures which are used by the Contractor for multiple lines of business and/or which are created for commercial purposes, and are also used to support the Work, shall not be subject to the Department's ownership rights. 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 that were specifically and solely designed, purchased or developed to perform the Work. Such data and software includes, but is not limited to, the following:

3.8.2.1. All computer software and programs, which have been designed or developed specifically and solely for the Department to perform the Work, or acquired by the Contractor on behalf of the Department specifically and solely to perform the Work, which are used in performance of the Contract.

3.8.2.2. All internal system software and programs specifically and solely developed by the Contractor or subcontractor to perform the Work, including all source codes, which

result from the performance of the Contract; excluding commercial software packages purchased under the Contractor's own license.

3.8.2.3. All necessary data files specifically and solely used to perform the Work.

3.8.2.4. User and operation manuals and other documentation specifically and solely designed, purchased or developed to perform the Work.

3.8.2.5. System and program documentation in the form specified by the Department specifically and solely as part of the Work.

3.8.2.6. Training materials developed for Department staff, agents or designated representatives in the operation and maintenance of this software that was specifically and solely designed, purchased or developed to perform the Work.

3.9. PERFORMANCE REVIEWS

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

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

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

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

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

3.10. CORRECTIVE ACTION PLANS

3.10.1. Upon request by the Department, the Contractor shall investigate any contract compliance concerns. The Contractor shall submit a written response to the Department that includes a brief description of the issue, the efforts that Contractor took to investigate the issue, the outcome of the Contractor's review.

3.10.1.1. The written response shall be sent to the Department within thirty (30) calendar days of the Department's request. Upon request, the Department may allow additional time to investigate and report.

3.10.1.1.1. DELIVERABLE: Compliance Concerns Response.

3.10.1.1.2. DUE: Within thirty (30) calendar days of the Department's request.

3.10.2. When the Department determines that Contractor is not in compliance with any term of this Contract, Contractor, upon written notification by the Department, shall develop a corrective action plan. Contractor shall prepare a Corrective Action Plan within thirty (30) calendar days of the receipt of a written request.

3.10.2.1. The Contractor shall notify the Department in writing, before the due date if it will not be able to present the corrective action plan within the thirty (30) days. The Contractor shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Contractor's compliance.

3.10.2.2. DELIVERABLE: Corrective Action Plan

3.10.2.3. DUE: Within thirty (30) days of receipt of a written request from the Department.

3.10.3. Upon receipt of the Contractor's corrective action plan, the Department shall accept, modify or reject the proposed corrective action plan. Modifications and rejects shall be accompanied by a written explanation.

3.10.3.1. In the event of a rejection of Contractor's corrective action plan the Contractor shall re-write the corrective action plan and resubmit it to the Department for review.

3.10.3.1.1. DELIVERABLE: Revised Corrective Action Plan.

3.10.3.1.2. DUE: Within fifteen (15) days of the Department's rejection.

3.10.4. Upon acceptance by the Department the Contractor shall implement the corrective action plan.

3.10.5. Contractor shall cooperate with any Department follow-up reviews or audits at any time after the initiation of the corrective action plan.

3.10.6. Corrective action plans shall include, but not be limited to:

3.10.6.1. A detailed time frame specifying the actions to be taken,

3.10.6.2. Contractor's employee(s) responsible for implementing the actions,

3.10.6.3. The implementation time frames and a date for completion.

3.10.7. Department staff shall monitor progress on the corrective action plan until the Contractor is found to be in compliance.

3.10.7.1. Department staff will notify 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.

3.10.8. If the Contractor notifies the Department that it will not be able to achieve compliance by the date specified in the Corrective Action Plan, and explains in writing its reasonable efforts to achieve compliance, the Department may grant an extension of the deadline, in writing, for Contractor compliance.

3.10.9. The Department reserves the right to reduce the time frame for a corrective action if delivery of Covered Services for Members is adversely affected.

3.10.10. If at the end of the specified time period, the Contractor has not demonstrated compliance, as determined by the Department, the Department may exercise any available remedy under this Contract.

3.10.11. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during corrective action periods.

3.11. RENEWAL OPTIONS

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

SECTION 4.0 START-UP AND CLOSEOUT PERIODS

4.1.1. The Contract shall have a Start-Up Period and a Closeout Period.

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

4.1.1.1.1. The Operational Start Date shall not occur until the Contractor has completed all requirements of the Start-Up Period.

4.1.1.1.2. 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.

4.1.1.2. 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 of 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.

4.1.1.2.1. This Closeout Period may extend past the termination of the Contract and the requirements of the Closeout Period shall survive termination of the Contract.

4.1.2. Start-Up Period

4.1.2.1. During the Start-Up Period, the Contractor shall complete all of the following:

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

4.1.2.1.1.1. DELIVERABLE: Policies and Procedure Manual

4.1.2.1.1.2. DUE: The later of five (5) days prior to the Operational Start Date, or the Effective Date unless more time is allowed and approved by the Department.

4.1.2.1.2. Prepare all documents, forms, training materials, and any other documents, information and protocols that require approval by the Department. The Contractor shall deliver all documents, forms, training materials, and any other documents, information and protocols that require approval by the Department to the Department for review and approval in a timely manner that allows the Department to review and approve those documents prior to end of the Start-Up Period.

4.1.2.1.3. Create and implement the Business Continuity Plan described in Section 3.7.

4.1.2.1.4. Create and implement the Communication Plan described in Section 3.6.

4.1.2.2. The Contractor shall provide bi-weekly updates, to the Department, throughout the Start-Up Period, that show the Contractor's status toward meeting the timelines and milestones described in the Contract.

4.1.2.3. The Contractor shall ensure that all requirements of the Start-Up Period are complete by the deadlines contained in the Contract and that the Contractor is operationally ready by the Operational Start Date.

4.1.3. Closeout Period

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

4.1.3.1.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

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

4.1.3.1.3. 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.

4.1.3.1.4. 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.

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

4.1.3.1.6. Notify all Clients that the Contractor will no longer be their assigned Behavioral Health Organization. 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 Clients, but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

4.1.3.1.6.1. DELIVERABLE: Client Notifications

4.1.3.1.6.2. DUE: Thirty (30) days prior to termination of the Contract

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

4.1.3.2. The Department will perform a closeout review to ensure that the Contractor has completed all requirements of the Closeout Period. The Contractor shall ensure that all responsibilities of the Closeout Period will be complete by the termination of the Contract. 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.

4.1.4. Closeout Planning

4.1.4.1. Closeout Plan

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

4.1.4.1.1.1. DELIVERABLE: Closeout Plan

4.1.4.1.1.2. DUE: Thirty (30) days following the Effective Date

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

4.1.4.1.2.1. DELIVERABLE: Closeout Plan Update

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

SECTION 5.0 COMPENSATION

5.1. COMPENSATION

5.1.1. The Department shall remit to the Contractor, on behalf of each Member who is eligible for Covered Services, the appropriate Monthly Capitation Rate for each full month for

which each Member is eligible for Covered Services, as specified by Exhibit B, on approximately the fifteenth (15th) Business Day of the month.

5.1.2. The Department shall remit to the Contractor a prorated Monthly Capitation Rate for any Member whose enrollment begins after the first (1st) of the month, including Members retroactively enrolled, based on the Rates as specified in Exhibit B.

5.1.3. Payment for retroactive eligibility months shall be made in the month following the date of the eligibility determination. The payment amount is calculated based on the capitation rates and the number of retroactive enrollment months, which is limited to three (3) months prior to the date that Medicaid eligibility is determined. 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.

5.1.4. 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.

5.2. RECONCILIATION

5.2.1. The Contractor shall be subject to the following reconciliation process:

5.2.1.1. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) calendar 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) calendar days, the Department shall deduct the overpayments from the next payment to the Contractor.

5.3. ADULT WITHOUT DEPENDENT CHILDREN RATE SETTLEMENTS

5.3.1. The Contractor and the Department shall engage in AwDC Rate Settlements for future calendar years based upon the information presented in an actuarial certification letter provided by the Department. Each AwDC Rate Settlement process shall include the following:

5.3.1.1. The Contractor shall send AwDC encounter data, together with the quarterly mental health encounter submissions, to the Department.

5.3.1.2. The Department will identify AwDC Clients by the capitation file.

5.3.1.3. The Department will calculate settlements by December 31st following each Calendar Year based upon the parameters set forth in the actuarial rate certification letter provided by the Department.

5.3.1.4. The Department will issue a demand letter by January 31st following each Calendar Year with the settlement amount that shall be either remitted to the Contractor or recouped from the Contractor.

EXHIBIT C, SAMPLE OPTION LETTER

Date:	Original Contract Routing # CMS #	Option Letter #	Contract Routing #

1) **OPTIONS:** Choose all applicable options listed in §1 and in §2 and delete the rest.
   - **a.** Option to renew only *(for an additional term)*
   - **b.** Change in the amount of goods within current term
   - **c.** Change in amount of goods in conjunction with renewal for additional term
   - **d.** Level of service change within current term
   - **e.** Level of service change in conjunction with renewal for additional term
   - **f.** Option to initiate next phase of a contract

2) **REQUIRED PROVISIONS**. All Option Letters shall contain the appropriate provisions set forth below:
   - **a. <u>For use with Options 1(a-e):</u>** In accordance with Section(s) of the Original Contract between the State of Colorado, Department of Health Care Policy and Financing **,** and Contractor's Name, the State hereby exercises its option for an additional term beginning Insert start date and ending on Insert ending date at a cost/price specified in Section , AND/OR an increase/decrease in the amount of goods/services at the same rate(s) as specified in Identify the Section, Schedule, Attachment, Exhibit etc.
   - **b. <u>For use with Option 1(f), please use the following:</u>** In accordance with Section(s) of the Original Contract between the State of Colorado, Department of Health Care Policy and Financing **,** and Contractor's Name, the State hereby exercises its option to initiate Phase indicate which Phase: 2, 3, 4, etc for the term beginning Insert start date and ending on Insert ending date at the cost/price specified in Section .
   - **c. <u>For use with all Options 1(a-f):</u>** The amount of the current Fiscal Year contract value is increased/decreased by $ amount of change to a new contract value of Insert New $ Amt to as consideration for services/goods ordered under the contract for the current fiscal year indicate Fiscal Year. The first sentence in Section is hereby modified accordingly. The total contract value including all previous amendments, option letters, etc. is Insert New $ Amt.

3) **Effective Date**. The effective date of this Option Letter is upon approval of the State Controller or , whichever is later.

STATE OF COLORADO
John W. Hickenlooper, GOVERNOR
Department of Health Care Policy and Financing

_____
By: Insert Name & Title of Person Signing for Agency or IHE

Date: _____

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

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

By: _____
Insert Name of Agency or IHE Delegate-Please delete if contract will be routed to OSC for approval
Date: _____

EXHIBIT D, COVERED BEHAVIORAL HEALTH DIAGNOSES

Part I- Mental Health Covered Diagnoses

295 - 298.9	
295	**Schizophrenic disorders**
	(the following fifth-digit sub-classification is for use with category 295)
0	unspecified
1	subchronic
2	chronic
3	subchronic with acute exacerbation
4	chronic with acute exacerbation
5	in remission
295.0	Simple type
295.1	Disorganized type
295.2	Catatonic type
295.3	Paranoid type
295.4	Acute schizophrenic episode
295.5	Latent schizophrenia
295.6	Residual type
295.7	Schizoaffective disorder
295.8	Other specified types of schizophrenia
295.9	Unspecified schizophrenia
296	**Episodic mood disorders**
	(the following fifth-digit subclassification is for use with categories 296.0-296.6)
0	unspecified
1	mild
2	moderate
3	severe, without mention of psychotic behavior
4	severe, specified as with psychotic behavior
5	in partial or unspecified remission
6	in full remission
296.0	Bipolar I disorder, single manic episode
296.1	Manic disorder, recurrent episode
296.2	Major depressive disorder, single episode
296.3	Major depressive disorder, recurrent episode
296.4	Bipolar I disorder, most recent episode (or current) manic
296.5	Bipolar I disorder, most recent episode (or current) depressed
296.6	Bipolar I disorder, most recent episode (or current) mixed
296.7	Bipolar I disorder, most recent episode (or current) unspecified

296.8	Other and unspecified bipolar disorders
296.80	Bipolar disorder, unspecified
296.81	Atypical manic disorder
296.82	Atypical depressive disorder
296.89	Other
296.9	Other and unspecified episodic mood disorder
296.90	Unspecified episodic mood disorder
296.99	Other specified episodic mood disorder
297	**Delusional disorders**
297.0	Paranoid state, simple
297.1	Delusional disorder
297.2	Paraphrenia
297.3	Shared psychotic disorder
297.8	Other specified paranoid states
297.9	Unspecified paranoid state
298	**Other nonorganic psychoses**
298.0	Depressive type psychosis
298.1	Excitative type psychosis
298.2	Reactive confusion
298.3	Acute paranoid reaction
298.4	Psychogenic paranoid psychosis
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
300 - 301.99	
300	**Anxiety, dissociative and somatoform disorders**
300.0	Anxiety states
300.00	Anxiety state, unspecified
300.01	Panic disorder without agoraphobia
300.02	Generalized anxiety disorder
300.09	Other
300.1	Dissociative, conversion and factitious disorders
300.10	Hysteria, unspecified
300.11	Conversion disorder
300.12	Dissociative amnesia
300.13	Dissociative fugue
300.14	Dissociative identity disorder
300.15	Dissociative disorder or reaction, unspecified
300.16	Factitious illness with predominantly psychological signs and symptoms
300.19	Other and unspecified factitious illness

300.2	Phobic disorders
300.20	Phobia, unspecified
300.21	Agoraphobia with panic attacks
300.22	Agoraphobia without mention of panic attacks
300.23	Social phobia
300.29	Other isolated or specific phobias
300.3	Obsessive-compulsive disorders
300.4	Dysthymic disorder
300.5	Neurasthenia
300.6	Depersonalization disorder
300.7	Hypochondriasis
300.8	Somatoform disorders
300.81	Somatization disorder
300.82	Undifferentiated somatoform disorder
300.89	Other Somatoform disorder
300.9	Unspecified nonpsychotic mental disorder
301	**Personality disorders**
301.0	Paranoid personality disorder
301.1	Affective personality disorder
301.10	Affective personality disorder, unspecified
301.11	Chronic hypomanic personality disorder
301.12	Chronic depressive personality disorder
301.13	Cyclothymic disorder
301.2	Schizoid personality disorder
301.20	Schizoid personality disorder, unspecified
301.21	Introverted personality
301.22	Schizotypal personality disorder
301.3	Explosive personality disorder
301.4	Obsessive-compulsive personality disorder
301.5	Histrionic personality disorder
301.50	Histrionic personality disorder, unspecified
301.51	Chronic factitious illness with physical symptoms
301.59	Other histrionic personality disorder
301.6	Dependent personality disorder
301.7	Antisocial personality disorder
301.8	Other personality disorders
301.81	Narcissistic personality disorder
301.82	Avoidant personality disorder
301.83	Borderline personality disorder
301.84	Passive-aggressive personality

301.89	Other
301.9	Unspecified personality disorder
307.1 - 309.99	
307	**Special symptoms or syndromes, not elsewhere classified**
307.1	Anorexia nervosa
307.2	Tics
307.20	Tic disorder, unspecified
307.21	Transient tic disorder
307.22	Chronic motor or vocal tic disorder
307.23	Tourette's disorder
307.3	Stereotypic movement disorder
307.4	Specific disorders of sleep of nonorganic origin
307.40	Nonorganic sleep disorder, unspecified
307.41	Transient disorder of initiating or maintaining sleep
307.42	Persistent disorder of initiating or maintaining sleep
307.43	Transient disorder of initiating or maintaining wakefulness
307.44	Persistent disorder of initiating or maintaining wakefulness
307.45	Circadian rhythm sleep disorder of nonorganic origin
307.46	Sleep arousal disorder
307.47	Other dysfunctions of sleep stages or arousal from sleep
307.48	Repetitive intrusions of sleep
307.49	Other
307.5	Other and unspecified disorders of eating
307.50	Eating disorder, unspecified
307.51	Bulimia nervosa
307.52	Pica
307.53	Rumination disorder
307.54	Psychogenic vomiting
307.59	Other
307.6	Enuresis
307.7	Encopresis
307.8	Pain disorders related to psychological factors
307.80	Psychogenic pain, site unspecified
307.81	Tension headache
307.89	Other
307.9	Other and unspecified special symptoms or syndromes, not elsewhere classified
308	**Acute reaction to stress**
308.0	Predominant disturbance of emotions

308.1	Predominant disturbance of consciousness
308.2	Predominant psychomotor disturbance
308.3	Other acute reactions to stress
308.4	Mixed disorders as reactions to stress
308.9	Unspecified acute reaction to stress
309	**Adjustment reaction**
309.0	Adjustment disorder with depressed mood
309.1	Prolonged depressive reaction
309.2	With predominant disturbance of other emotions
309.21	Separation anxiety disorder
309.22	Emancipation disorder of adolescence and early adult life
309.23	Specific academic or work inhibition
309.24	Adjustment disorder with anxiety
309.28	Adjustment disorder with mixed anxiety and depressed mood
309.29	Other
309.3	Adjustment disorder with disturbance of conduct
309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.8	Other specified adjustment reactions
309.81	Post-traumatic stress disorder
309.82	Adjustment reaction with physical symptoms
309.83	Adjustment reaction with withdrawal
309.89	Other
309.9	Unspecified adjustment reaction
311 - 314.9	
311	**Depressive disorder, not elsewhere classified**
312	**Disturbance of conduct, not elsewhere classified**
	(the following fifth-digit sub-classification is for use with categories 312.0-312.2)
0	unspecified
1	mild
2	moderate
3	severe
312.0	Undersocialized conduct disorder, aggressive type
312.1	Undersocialized conduct disorder, unaggressive type
312.2	Socialized conduct disorder
312.3	Disorders of impulse control, not elsewhere classified
312.30	Impulse control disorder, unspecified
312.31	Pathological gambling
312.32	Kleptomania
312.33	Pyromania
312.34	Intermittent explosive disorder

312.35	Isolated explosive disorder
312.39	Other
312.4	Mixed disturbance of conduct and emotions
312.8	Other specified disturbance of conduct, not elsewhere classified
312.81	Conduct disorder, childhood onset type
312.82	Conduct disorder, adolescent onset type
312.89	Other conduct disorder
312.9	Unspecified disturbance of conduct
313	**Disturbance of emotions specific to childhood and adolescence**
313.0	Overanxious disorder
313.1	Misery and unhappiness disorder
313.2	Sensitivity, shyness, and social withdrawal disorder
313.21	Shyness disorder of childhood
313.22	Introverted disorder of childhood
313.23	Selective mutism
313.3	Relationship problems
313.8	Other or mixed emotional disturbances of childhood or adolescence
313.81	Oppositional defiant disorder
313.82	Identity disorder
313.83	Academic underachievement disorder
313.89	Other
313.9	Unspecified emotional disturbance of childhood or adolescence
314	**Hyperkinetic syndrome of childhood**
314.0	Attention deficit disorder
314.00	Without mention of hyperactivity
314.01	With hyperactivity
314.1	Hyperkinesis with developmental delay
314.2	Hyperkinetic conduct disorder
314.8	Other specified manifestations of hyperkinetic syndrome
314.9	Unspecified hyperkinetic syndrome

Part 2- Substance Use Disorder Covered Diagnoses

ICD-9		DSM-IV	
Alcohol Use Disorders			
291	Alcohol-induced mental disorders	--	No equivalent DSM-IV code
303	Alcohol dependence syndrome	--	No equivalent DSM-IV code

303.9 [0-3]*	Other and unspecified alcohol dependence	303.90	Alcohol dependence
305.0 [0-3]	Alcohol abuse	305.00	Alcohol abuse
305	Nondependent abuse of drugs	--	No equivalent DSM-IV code
Alcohol-Induced Disorders			
303.0 [0-3]	Acute alcohol intoxication	303.00	Alcohol intoxication
291.81	Alcohol withdrawal	291.81	Alcohol withdrawal
291.0	Alcohol withdrawal delirium	291.0	Alcohol withdrawal delirium
291.0	Alcohol intoxication delirium	291.0	Alcohol intoxication delirium
291.1	Alcohol induced persisting amnesic disorder	291.1	Alcohol induced persisting amnesic disorder
291.5	Alcohol induced psychotic disorder with delusions	291.5	Alcohol induced psychotic disorder with delusions
291.3	Alcohol induced psychotic disorder with hallucinations	291.3	Alcohol induced psychotic disorder with hallucinations
291.89	Other alcohol induced mood disorder	291.89	Alcohol induced mood disorder
291.89	Other alcohol induced anxiety disorder	291.89	Alcohol induced anxiety disorder
291.89	Other alcohol induced sexual dysfunction	291.89	Alcohol induced sexual dysfunction
291.82	Alcohol induced sleep disorders	291.82	Alcohol induced sleep disorders
291.9	Unspecified alcohol induced mental disorders	291.9	Alcohol-related disorder not otherwise specified (NOS)

Amphetamine Use Disorders			
304	Drug dependence	--	No equivalent DSM-IV code
304.4 [0-3]	Amphetamine and other psychostimulant dependence	304.40	Amphetamine dependence
305.7 [0-3]	Amphetamine or related acting sympathomimetic abuse	305.70	Amphetamine abuse
Amphetamine Induced Disorders			
292	Drug-induced mental disorders	--	No equivalent DSM-IV code
292.89	Other specified drug induced mental disorder	292.89	Amphetamine intoxication
292.0	Drug withdrawal	292.0	Amphetamine withdrawal
292.81	Drug induced delirium	292.81	Amphetamine intoxication delirium

292.11	Drug induced psychotic disorder with delusions	292.11	Amphetamine induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Amphetamine induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Amphetamine induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Amphetamine induced anxiety disorder
292.89	Drug induced sexual dysfunction	292.89	Amphetamine induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Amphetamine induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Amphetamine related disorders not otherwise specified

Cannabis Use Disorders			
304.3 [0-3]	Cannabis dependence	304.30	Cannabis dependence
305.2 [0-3]	Cannabis abuse	305.20	Cannabis abuse
Cannabis Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Cannabis intoxication
292.81	Drug-intoxication delirium	292.81	Cannabis intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Cannabis induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Cannabis induced psychotic disorder with hallucinations
292.89	Drug induced anxiety disorder	292.89	Cannabis induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Cannabis related disorders not otherwise specified (NOS)

Cocaine Use Disorders			
304.2 [0-3]	Cocaine dependence	304.20	Cocaine dependence
305.6 [0-3]	Cocaine abuse	305.60	Cocaine abuse
Cocaine Induced Disorders			

292.89	Other specified drug induced mental disorder	292.89	Cocaine intoxication
292.0	Drug withdrawal	292.0	Cocaine withdrawal
292.81	Drug intoxication delirium	292.81	Cocaine intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Cocaine induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Cocaine induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Cocaine induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Cocaine induced anxiety disorder
292.89	Drug induced sexual dysfunction	292.89	Cocaine induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Cocaine induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Cocaine related disorders not otherwise specified (NOS)

Hallucinogen Use Disorders			
304.5 [0-3]	Hallucinogen dependence	304.50	Hallucinogen dependence
305.3 [0-3]	Hallucinogen abuse	305.30	Hallucinogen abuse
Hallucinogen Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Hallucinogen intoxication
292.89	Other specified drug induced mental disorders	292.89	Hallucinogen persisting perception disorder (flashbacks)
292.81	Drug induced delirium	292.81	Hallucinogen intoxication delirium
292.11	Drug induced psychotic disorder with delusions	**292.11**	**Hallucinogen induced psychotic disorder with delusions**
292.12	Drug induced psychotic disorder with hallucinations	**292.12**	**Hallucinogen induced psychotic disorder with hallucinations**
292.84	Drug induced mood disorder	292.84	Hallucinogen induced mood disorder

292.89	Drug induced anxiety disorder	292.89	Hallucinogen induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Hallucinogen related disorders not otherwise specified (NOS)

Inhalant Use Disorders			
304.6 [0-3]	Other specified drug dependence	304.60	Inhalant dependence
305.9 [0-3]	Other, mixed, or unspecified drug abuse	305.90	Inhalant abuse
Inhalant Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Inhalant intoxication
292.81	Drug induced delirium	292.81	Inhalant intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Inhalant induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Inhalant induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Inhalant induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Inhalant induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Inhalant related disorders not otherwise specified

Opioid Use Disorders			
304.0 [0-3]	Opioid type dependence	304.00	Opioid dependence
305.5 [0-3]	Opioid abuse	305.50	Opioid abuse
Opioid Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Opioid intoxication
292.0	Drug withdrawal	292.0	Opioid withdrawal
292.81	Drug induced delirium	292.81	Opioid intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Opioid induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Opioid induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Opioid induced mood disorder
292.89	Drug induced sexual dysfunction	292.89	Opioid induced sexual dysfunction

292.85	Drug induced sleep disorder	292.85	Opioid induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Opioid related disorders not otherwise specified

Phencyclidine Use Disorders			
304.6 [0-3]	Other specified drug dependence	304.60	Phencyclidine dependence
305.9 [0-3]	Other, mixed, or unspecified drug use	305.90	Phencyclidine abuse
Phencyclidine Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Phencyclidine intoxication
292.81	Drug intoxication delirium	292.81	Phencyclidine intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Phencyclidine induced psychotic disorder with delusions
292.12	Drug induced psychotic Disorder with hallucinations	292.12	Phencyclidine induced psychotic Disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Phencyclidine induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Phencyclidine induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Phencyclidine related disorders not otherwise specified (NOS)

Sedative-,Hypnotic-,or Anxiolytic Use Disorders			
304.1 [0-3]	Sedative-,hypnotic-,or anxiolytic dependence	304.10	Sedative-,hypnotic-,or anxiolytic dependence
305.4 [0-3]	Sedative-,hypnotic-,or anxiolytic abuse	305.40	Sedative-,hypnotic-,or anxiolytic abuse
Sedative-,Hypnotic-,or Anxiolytic-Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Sedative-,hypnotic-,or anxiolytic intoxication
292.0	Drug withdrawal	292.0	Sedative-,hypnotic-,or anxiolytic withdrawal
292.81	Drug induced delirium	292.81	Sedative-,hypnotic-,or anxiolytic intoxication delirium
292.83	Drug induced persisting amnestic disorder	292.83	Sedative-,hypnotic-,or anxiolytic induced persisting amnestic disorder

292.11	Drug induced psychotic disorder with delusions	292.11	Sedative-,hypnotic-,or anxiolytic induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Sedative-,hypnotic-,or anxiolytic induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Sedative-,hypnotic-,or anxiolytic induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Sedative-,hypnotic-,or anxiolytic induced anxiety disorder
292.89	Drug induced sexual dysfunction	292.89	Sedative-,hypnotic-,or anxiolytic induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Sedative-,hypnotic-,or anxiolytic induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Sedative-,hypnotic-,or anxiolytic-related disorder not otherwise specified
304.7 [0-3]	Combinations of opioid type drug with any other	*	Polysubstance dependence
304.8 [0-3]	Combinations of drug dependence excluding opioid type drug	304.80	Polysubstance dependence

Tobacco Use Disorder			
305.1	Tobacco use disorder	305.1	Nicotine Dependence

--No equivalent DSM IV code

*Fifth digit sub-classification Subcategories:

[0 unspecified; 1 continuous; 2 episodic; 3 in remission]

EXHIBIT E, COVERED BEHAVIORAL HEALTH PROCEDURES CODES

Proc Code	Full description of the procedure codes
00104	Anesthesia for electroconvulsive therapy
90785	Interactive complexity (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90837	Psychotherapy, 60 minutes with patient and/or family
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90870	Electroconvulsive therapy (includes necessary monitoring)
90875	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.

96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing by a computer, with qualified health care professional interpretation and report.
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
98966	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99221	Initial Hospital Care Low Complexity
99222	Initial Hospital Care Moderate Complexity
99223	Initial Hospital Care High Complexity
99231	Subsequent Hospital Care Low Complexity
99232	Subsequent Hospital Care Moderate Complexity
99233	Subsequent Hospital Care High Complexity
99238	Hospital Discharge Day Management/30 minutes
99239	Discharge day management; more than 30 minutes
99251	Initial Inpatient Consultation/20 minutes
99252	Initial Inpatient Consultation/40 minutes
99253	Initial Inpatient Consultation/55 minutes
99254	Initial Inpatient Consultation/80 minutes

99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional.
99367	Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by non-physician qualified health care professional
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).
*H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0004	Behavioral health counseling and therapy, per 15 minutes
*H0005	Alcohol and/or drug services; group counseling by a clinician
*H0006	Alcohol and/or drug services; case management (targeted)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0020	Medication Assisted Treatment
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem

H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes. Long definition: The purpose of Comprehensive Community Support Services is to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. Comprehensive Community Support Services identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multi-systemic therapy for juveniles, per 15 minutes
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders
*S3005	Safety assessment including suicidal ideation and other behavioral health issues
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
*S9445	Drug screening and monitoring
S9453	Smoking cessation classes, non-physician provider, per session
S9454	Stress management classes, non-physician provider, per session
S9480	Intensive outpatient psychiatric services, per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care services, up to 15 minutes
*T1007	Physical assessment of detoxification progression including vital signs monitoring
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

*T1019	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients
*T1023	Level of motivation assessment for treatment evaluation

*Denotes services that have been approved by the Joint Budget Committee (JBC) for inclusion in the substance use disorder benefit.

Please note: The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

The below list of Evaluation and Management codes are covered by the BHOs when they are billed in conjunction with a psychotherapy add-on from the above list or when used for the purposes of medication management with minimal psychotherapy provided by a prescriber from the BHO network.

99201	Office or other outpatient visit, new patient/ 10 minutes
99202	Office or other outpatient visit, new patient/ 20 minutes
99203	Office or other outpatient visit, new patient/ 30 minutes
99204	Office or other outpatient visit, new patient/ 45 minutes
99205	Office or other outpatient visit, new patient/ 60 minutes
99211	Office or other outpatient visit, established patient/ 5 minutes
99212	Office or other outpatient visit, established patient/10 minutes
99213	Office or other outpatient visit, established patient/ 15 minutes
99214	Office or other outpatient visit, established patient/ 25 minutes
99215	Office or other outpatient visit, established patient/ 40 minutes
99217	Observation care discharge day management
99218	Initial observation / 30 minutes
99219	Initial observation care/ 50 minutes
99220	Initial observation care/ 70 minutes
99224	Subsequent observation care/ 15 minutes
99225	Subsequent observation care/ 25 minutes
99226	Subsequent observation care/ 35 minutes
99234	Observation or inpatient hospital care, patient admitted and discharged on same date of service, 40 minutes
99235	Observation or inpatient hospital care, patient admitted and discharged on same date of service/50 minutes
99236	Observation or inpatient hospital care, patient admitted and discharged on same date of service/ 55 minutes
99241	Office consultation/ 15 minutes
99242	Office consultation/ 30 minutes
99243	Office consultation/ 40 minutes
99244	Office consultation/ 60 minutes
99245	Office consultation/ 80 minutes
99255	Initial inpatient consultation/ 110 minutes.
99304	Initial nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99305	Initial nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99306	Initial nursing facility care/per day/ 45 minutes spent at bedside or on patient floor/unit
99307	Subsequent nursing facility care/per day/ 10 minutes spent at bedside or on patient floor/unit
99308	Subsequent nursing facility care/per day/ 15 minutes spent at bedside or on patient floor/unit

99309	Subsequent nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99310	Subsequent nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99315	Nursing facility discharge day management/ 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Annual nursing facility assessment/ 30 minutes spent at bedside or on patient floor/unit
99324	Domiciliary or rest home visit, new patient/ 20 minutes
99325	Domiciliary or rest home visit, new patient/ 30 minutes
99326	Domiciliary or rest home visit, new patient/ 45 minutes
99327	Domiciliary or rest home visit, new patient/ 60 minutes
99328	Domiciliary or rest home visit, new patient/ 75 minutes
99334	Domiciliary or rest home visit, established patient/ 15 minutes
99335	Domiciliary or rest home visit, established patient/ 25 minutes
99336	Domiciliary or rest home visit, established patient/ 40 minutes
99337	Domiciliary or rest home visit, established patient/ 60 minutes
99341	Home visit, new patient/20 minutes
99342	Home visit, new patient/30 minutes
99343	Home visit, new patient/45 minutes
99344	Home visit, new patient/60 minutes
99345	Home visit, new patient/75 minutes
99347	Home visit, established patient/15 minutes
99348	Home visit, established patient/25 minutes
99349	Home visit, established patient/40 minutes
99350	Home visit, established patient/60 minutes

Please Note: This list of covered procedures is to be used as a guideline rather than a contractual requirement. The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

EXHIBIT F, COMBINED CORE COMPETENCIES

Combined Core Competencies for Colorado's Peer Specialists / Recovery Coaches And Family Advocates / Family Systems Navigators

Knowledge of Mental Health/Substance Use Conditions and Treatments
- Recognize signs and coping strategies, including the grief process
- Know when to refer to a clinician
- Know when to report to a supervisor
- Understand interactions of physical and behavioral health

Clients Rights/Confidentiality/Ethics/Roles
- Understand scope of duties and role
- Understand HIPAA / protected health information / confidentiality
- Maintain professional boundaries
- Recognize potential risks
- Advocate when appropriate

Interpersonal Skills
- Communication
- Diversity and cultural competency
- Relationship development
- Use guiding principles pertinent to population served
- Model appropriate use of personal story and self-advocacy
- Goal-setting, problem-solving, teamwork, & conflict resolution

Resiliency, Recovery and Wellness
- Understand principles and concepts of resiliency, recovery, and a wellness oriented lifestyle
- Assist others with their own resiliency and recovery
- Encourage options and choices
- Understand impacts of labels, stigma, discrimination, and bullying
- Understand person-centered resiliency and recovery planning for all ages and stages
- Promote shared decision-making

Resources
- Knowledge of community resources and those specific to behavioral health and physical Health and how to navigate the benefits system
- Help individuals and families recognize their natural supports

***** Knowledge of public education and special education system and other child-serving systems

Self-care
- Recognize when health may compromise the ability to work
- Acknowledge that personal wellness is a primary responsibility
- Set boundaries between work and personal life

Teaching Skills
- Demonstrate wellness and teach life skills
- Encourage the development of natural supports
- Assist people to find and use psycho-education materials

Basic Work Competencies
- Seek supervision and/or ask for direction
- Accept feedback
- Demonstrate conflict resolutions skills
- Navigate complex work environments

Trauma-Informed Support
- Understand impact of trauma and responses to trauma

- Demonstrate sensitivity and acceptance of individual experiences
- Practice cultural sensitivity
- Promote shared decision-making
* Item pertains specifically to Family Advocates / Family Systems Navigators

Sources of Information and Input:

1. Advocates for Recovery – Colorado *Core Competencies for Recovery Coaches*, (2010)
2. Blanch, A., Filson, B., & Penney, D. *Engaging Women in Trauma-Informed Peer Support: A Guidebook*
(2012)
3. *Colorado Mental Health Advocates' Forum Peer Specialist Core Competencies*, as adopted by the
Colorado Department of Health Care Policy and Financing (HCPF) in its *Medicaid Community Mental*
Health ServicesProgram Request for Proposals released December 2008.
4. *Colorado Mental Health Advocates' Forum Consensus Statement on Resiliency* (2012)
5. Colorado *Mental Health Advocates' Forum Consensus Statement on Trauma-Informed Care* (2012)
6. National Federation of Families for Children's Mental Health *Certified Parent Support Specialist Self-*
Assessment Training Checklist, Sept. 2011, from the National Federation website.
7. *SAMHSA's Working Definition of Recovery* (Dec. 2011), retrieved from the U.S. Department of Health
and Human Services, Substance Abuse and Mental Health Services Administration website
8. House Bill 1193 – Concerning Integrated System-of-Care Family Advocacy Programs for Mental Health
Juvenile Justice Populations. (2011)

EXHIBIT G, PERFORMANCE MEASURES

#	Priority	Performance Measure	Source	Notes
1	C Threshold	Emergency Room Visits (per 1000 Members)	As describe in the "Key Performance Indicator Calculations for ACC Incentive Payments" White Paper	KPI, CHIPRA Pediatric Core
2	C	Emergency Dept. Utilization (per 1000 Members) for mental health condition	BHO-HCPF 2013 Scope Document #18	
3	C Threshold	Hospital Readmissions	As describe in the "Key Performance Indicator Calculations for ACC Incentive Payments" White Paper	KPI, AMQM measure, Health Home measure, MM Demonstration measure
4	C	Follow-up appointments within thirty (30) days after hospital discharge for mental health condition.	HEDIS	AMQM measure, Health home measure, MM Demonstration measure
5	C	SMI clients with physical health well care visit	BHO-HCPF 2013 Scope Document #15	(addresses access to physical health provider and coordination)
6	C	Percentage of children receiving developmental screening in the first three years of life.	CMS 416	
7	C	BHO Inpatient Utilization (per 1000 Members)	BHO-HCPF 2013 Scope Document #16	
8	C	Appropriate utilization and follow up for children prescribed medication for ADHD	NCQA 0108 2009 CHIPRA Core Measure	
9	C	Psychotropic utilization in children Antipsychotic Utilization in children. Psychotropic utilization for children in child welfare	Drug Utilization Review (DUR)	
10	C	Antidepressant medication management – acute and continuation phases	HEDIS	AMQM measure

#	Priority	Performance Measure	Source	Notes
11	C	Progress toward Independent Living for Members with Severe Mental Illness (SMI)	BHO-HCPF 2013 Scope Document #7	
12	C	Penetration Rates (Behavioral Health Utilzation by BHO)	BHO-HCPF 2013 Scope Document #8-#11	
13	C	Adherence to antipsychotics for individuals with schizophrenia	HEDIS	AMQM measure
14	C	MHSIP, YSSF, & YSS Satisfaction Surveys	BHO-HCPF 2013 Scope Document #19	
15	C	Mental Health Engagement: Individuals accessing behavioral health services with 4 visits in 45 days.	BHO-HCPF scope document.	
16	C	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Washington Circle	AMQM measure, Health home measure, MM Demonstration measure
17	C	Number of Children receiving intensive services in the community/home	No source	
18	C	Depression Screening and Follow-up Care	HEDIS	AMQM measure, Health home measure, MM Demonstration measure
19	C	Mothers reporting trauma and/or intimate partner violence % of mothers that had a health care professional talk with them about what to do if they experience postpartum depression/ Behavioral Risk Assessment for Pregnant women	PRAMS (total population only available) PRAMS (total population only available) CHIPRA Core Set 2009	Shared Measure Set (CDPHE, HCPF, OBH)
20	C	Adult Body Mass Index (BMI) assessment and follow-up		AMQM measure, Health Home measure
21	C	Ambulatory Care-Sensitive Conditions.	CMS Health Home Core Quality Measures	(AMQM for diabetes, COPD and asthma) Health Home measure, MM demonstration measure

#	Status Check	Performance Measure	Source	Notes
22	SC	Maintaining Independent Living Status for Members with Severe Mental Illness (SMI)	BHO-HCPF Scope 2013 Document #6	
23	SC	Percent of Members prescribed redundant or duplicated antipsychotic medication	BHO-HCPF 2013 Scope Document #2 CNS Pharmacy	
24	SC	% of patients w/ serious/severe MH with blood glucose monitoring- Diabetes monitoring for individuals diagnosed with schizophrenia or prescribed antipsychotic medications	Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy January 12, 2010 HEDIS	Similar to first year HEDIS measure
25	SC	% of patients w/ serious/severe MH with lipid monitoring Cardiovascular Monitoring for individuals diagnosed with Cardiovascular Disease and Schizophrenia	Cascades Community Engagement Behavioral Health Integration Measurement/Evaluation Strategy January 12, 2010 HEDIS	Similar to first year HEDIS measure
26	SC	Care for Older Adults Advance care planning, medication review, functional status assessment and pain screening	HEDIS	Hybrid methodology, requires Medicare claims and Part D data

Proposed RFP Performance Measures Key	
Measure Count Type	**Number**
Core	21
Status Check	5
Total # of Measures	**26**
Priority Definitions	**Definition**
Core Threshold Measures	Core Regional Care Collaborative Organization (RCCO) Key Performance Indicators (Emergency Visits, Hospital Re-admissions). BHO plans will work with the RCCO to improve these measures.
Core	Core measures that will be in place from the time the contract begins. Data submission will be either quarterly, semi-annually or annually, depending on the measure.
Status Check Measures (SC)	Measures that are not calculated for the reporting year, but can be added to the Core list or requested for a spot check calculation.

EXHIBIT H, PROCEDURE CODES EXEMPT FROM CCAR

97535	Self care management training
97537	Community/work reintegration
H0002	Behavioral health screening
H0023	Alcohol and/or drug outreach
H0025	Alcohol and/or drug prevention
H0038	Self-help/peer svc per 15mm
H 2015	Comp comm supp svc, 15 mm
H 2016	Comp comm supp svc, per diem
H2027	Psycho-ed svc, per 15 mm (non clinician only)
H2030	MI-I clubhouse svc, per 15 mm
H2031	MH clubhouse svc, per diem
S9453	Smoking cessation class
S9454	Stress mgmt class

EXHIBIT I, EVALUATION AND TREATMENT OF COVERED METAL ILLNESS (MI) IN PEOPLE WITH TRAUMATIC BRAIN INJURY (TBI)

BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI).

People with traumatic brain injuries should be given the same access to mental health services as the general Medicaid population. The intent of this document is to make sure that a diagnosis of traumatic brain injury does not preclude an individual from receiving a diagnosis and treatment of a covered mental illness, if appropriate. As with any other population, individuals with TBI are at risk for increased symptoms, impairment, and disability without accurate assessment and appropriate treatment.

Although behavioral problems are not universal in the TBI population, many individuals with a TBI do experience problems with impulse control and self-management of their behavior. Clients may have problems with mood swings, depression, anxiety and psychosis. These problems can be related to the traumatic brain injury, reactive psychological processes and/or co-occurring mental illness diagnoses.

The high rate of co-occurring general medical conditions can further complicate the diagnostic profile and management for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's organic brain pathology, and/or mental illness covered under the Colorado Medicaid Community Mental Health Services Program is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document has been developed by several organizations with experience in this area. They include Behavioral Health Organizations (BHOs), the Department of Health Care Policy and Financing, traumatic brain injury treatment professionals, consumer advocates and other key stakeholders.

This document attempts to define criteria for service access and appropriate billing (capitation vs. fee for service) for use by evaluating clinicians and BHO/Community Mental Health Center (CMHC) administrators. It is not intended to fully describe the collaboration between providers, or between BHOs and other providers. All contributors to this document, including family members and advocates, embrace the value of systems working together.

The Colorado BHOs have adopted the following Practice Standards for Medicaid recipients with a traumatic brain injury:

1. Under no circumstance does the presence of TBI preclude an assessment for and treatment of co-occurring mental illness covered under the Colorado Medicaid

Community Mental Health Services Program. BHOs will not deny services for a covered diagnosis on the basis that the covered diagnosis is not primary, and regardless of etiology. For example, a client presenting with post-traumatic stress disorder which developed as a result of a brain injury will be treated for the PTSD, regardless of whether or not the PTSD was caused from incident in which the brain injury occurred. The presence of a covered diagnosis and the BHO's determination that the issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A BHO provider will complete a face-to-face assessment with any child, youth, or adult with TBI who is referred for evaluation for covered mental illness according to the provider's regular intake and admission procedures and standards. For clients whose traumatic brain injury or level of functioning does not allow for the use of standard assessment procedures, the BHO will request needed information from other sources such as the client's providers, case manager, or family member when available. When these resources are not available, the BHO shall consult outside professionals with expertise in brain injury.

3. The BHO will ensure assessment on any re-referred client for whom the last assessment is older than 120 days.

4. If a consumer is referred for a second assessment within 120 days of being denied services as a result of the determination that their symptoms are not covered under the current contract, the BHO will consider the following when determining medical necessity:

a. There has been a change in the consumer's mental status, or
b. New and relevant information has been provided.

If so, the BHO will arrange for another mental health assessment based on the new information and/or mental status changes reported.

5. Referral for evaluation of Medicaid recipients with TBI can be made 24 hours a day, 7 days a week through the BHO's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the BHO. Emergency referrals may be evaluated either within a BHO network site or by BHO staff in a hospital Emergency Department or other safe environment. After hours emergency referrals are to be evaluated in a safe environment, usually in a hospital Emergency Department. BHO providers shall make reasonable efforts to contract with an expert in TBI in order to provide consultation.

7. If there are diagnostic uncertainties, all evaluations during regular working hours are reviewed by an experienced licensed professional within the BHO provider network. Any decision to deny services to a consumer with a traumatic brain injury will be reviewed by the BHO Medical Director or physician designee. All after hours evaluations will be reviewed with the on-call psychiatrist prior to a denial being issued. In addition, BHO policy dictates that an initial appeal of any decision to deny a request for services requires that the denial be reviewed by a psychiatrist other than the psychiatrist who issued the first denial.

8. BHOs may utilize courtesy emergency evaluations from other BHOs. BHOs may also utilize hospital emergency department personnel to conduct an evaluation on a client outside the network area. If treatment is medically necessary (as defined in item #9 below) outside the network area, the BHO will negotiate an arrangement with a qualified provider to deliver the medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Colorado Medicaid Community Mental Health Services Program. Evidence that the referring symptoms are associated with that covered mental illness, evidence that treatment of the symptoms is medically necessary, and an assurance that treatment is provided within the least restrictive environment is necessary. The HCPF document, labeled "Exhibit D – Covered Diagnoses" from the 2009 contract accompanies this document and is available from HCPF or any BHO.

10. Services may be authorized either in whole or in part based upon determination of the underlying cause of the symptoms presented at the time. If it is determined that the individual does not have a covered diagnosis, the BHO will refer the individual to a specialist provider covered under the Medicaid fee for service program.

11. At the time of evaluation, the BHO will review all relevant and available information including records of past diagnoses and treatments. However, the BHO does not recognize "by history" diagnoses and will evaluate the provider's diagnostic formulation based on the prevalence of the medical evidence available at the time. If there is not enough evidence available to accept or challenge the diagnostic formulation of the provider, the BHO may defer its final authorization decision until sufficient information has been received. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

12. Cases in which the BHO evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary or not covered by the BHO, the consumer, family member, Case Manager and/or authorized representative will be given detailed written information about the clinical rationale for the denial. The BHO will also provide information about all available appeal rights and assistance with filing an appeal through the BHO.

14. The BHOs acknowledge that diagnoses often "evolve" over a period of time as the natural progression of a disorder further defines itself. Often, new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In situations in which the provider changes a previous diagnostic formulation, the provider will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the BHO Medical Director or physician designee will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the BHO contract is the DSM-5 criteria for that diagnosis. While currently the ICD-9 is the standard by which diagnoses are coded for billing and reporting purposes, the DSM-5 remains the clinical standard by which diagnostic criteria are met and diagnoses are established. DSM-5 criteria must be met to support diagnoses even though billing and reporting will ultimately be submitted under ICD-9 codes. BHO contracted providers follow conventional diagnostic practice in considering whether diagnostic criteria are met, and consider that symptomatology may present atypically in individuals with a TBI. However, a diagnosis cannot be made in the absence of reasonably meeting criteria even in the context of an atypical presentation. Diagnostic evaluations will include a review of preexisting conditions, premorbid functioning, family medical and psychiatric history, prior treatment and evaluations, past and current response to treatment including prescribed medications, and past and current symptomatology and behavioral presentation as described by the individual, care providers, family members and other information sources.

2. Other diagnoses, including the traumatic brain injury, must be present to explain variances from diagnostic criteria.

3. Consideration is given to the consumer's abilities or disabilities in how diagnostic criteria present themselves.

4. Upon completion of a diagnostic evaluation as described in Guiding Principle #1, if a specific diagnosis is established with a reasonable degree of certainty, additional diagnoses will not be considered in authorizing services.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the consumer, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the consumer, and are provided in the least restrictive setting where services can safely be provided.

7. BHO Medicaid recipients with traumatic brain injury have access to the full spectrum of appeal rights under the Colorado Medicaid Community Mental Health Services Program for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary. Future review could involve expanding these guidelines.

EXHIBIT J, DEVELOPMENTAL DISABILITY (DD)

BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD)

Providing services to individuals with both a mental illness and a developmental disability is a complicated challenge to the provider community in meeting a DD/MI individual's behavioral health needs. Co-occurring mental health disorders and developmental disabilities are relatively common. People with developmental disabilities should be afforded the same access to mental health services as the general population. The intent of this document is to ensure that the presence of a diagnosis of developmental disability does not decrease the diagnostic significance of any accompanying mental illness. A misdiagnosis could result in the use of inappropriate or ineffective interventions.

Although behavioral problems are not universal among the DD population, many individuals with a developmental disability do show problems with impulse control, self-management of their behavior, and may have problems with mood swings, which may or may not be part of their developmental delay. The high rate of co-occurring neurological and general medical conditions can further complicate the diagnostic profile for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's developmental disability, organic brain pathology, and/or mental illness covered under the Colorado Medicaid Community Mental Health Services Program is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document has been developed by the Behavioral Health Organizations (BHOs) in collaboration with Community Center Boards (CCBs), developmental disability professionals, consumer advocates and other key stakeholders, in the interest of fulfilling their responsibilities under the Colorado Medicaid Community Mental Health Services Program, and to meet the BHO/HCPF contract requirement, which states, "The Contractor [BHO] shall develop written criteria for determining whether the need for mental health services for a Medicaid recipient with co-occurring mental illness and developmental Disabilities is a result of the individual's mental illness, or a result of the individual's developmental Disability…The criteria shall be approved by the Department." The document is an attempt to define these criteria for use by evaluating clinicians. It is not intended to fully describe the collaboration between providers, BHOs and CCBs, that is both required and embraced as values (and in most cases as a reality) by those organizations, by families, and by advocates for individuals with DD/MI. The Colorado BHOs have adopted the following Practice Standards for their Medicaid recipients with a developmental disability:

1. In no circumstance, does the presence of DD preclude an assessment for co-occurring mental illness covered under the Colorado Medicaid Community Mental Health Services Program. BHOs and their contracted providers will not deny services for a covered diagnosis on the basis of that covered diagnosis not being primary. The presence of a covered diagnosis and the BHO's determination that the issues requiring treatment are

related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A BHO provider will complete a face-to-face assessment on any child, youth, or adult with DD who is referred for evaluation for covered mental illness according to that BHO's regular intake and admission procedures and standards. The BHO will provide a mental health assessment for any child, youth or adult with a developmental disability who is referred for evaluation of a covered mental illness. For consumers whose developmental disability and/or level of functioning precludes the use of standard evaluation protocols, the BHO will solicit the participation and/or assistance from someone, such as the CCB case manager, or family member, who can provide information needed to conduct the assessment. Evaluations will be conducted in a secure setting to ensure the safety of a consumer who is behaviorally out of control.

3. The BHO will complete a new face-to-face assessment on any re-referred consumer in which its last assessment is greater than 120 days old.

4. In the specific circumstance in which a BHO provider has assessed a consumer with DD within the past 120 days and services have been denied, and the consumer is re-referred for another assessment within that 120-day window, the BHO will re-assess whether there has either been a change in the consumer's mental status or if new and relevant information have been provided
.
5. Referral for evaluation of Medicaid recipients with DD can be made 24 hours a day, 7 days a week through the BHO's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the BHO. Emergency referrals may be evaluated either within a BHO network site or by BHO staff in a hospital Emergency Department or other safe environment. After-hours emergency referrals are evaluated in a safe environment, usually in a hospital Emergency Department.

7. All evaluations during regular working hours are reviewed by an experienced licensed professional within the BHO provider network if there are diagnostic uncertainties. Any decision to deny services to a consumer with a developmental disability will be reviewed by the BHO Medical Director or physician designee. All after-hours evaluations are reviewed with the on-call psychiatrist prior to a denial being issued. In all BHOs, an initial appeal of any decision to deny a request for services requires that the denial be reviewed by another psychiatrist other than the psychiatrist who issued the first denial.

8. BHOs may also utilize courtesy evaluations from other BHOs, and/or delegate emergency assessment to hospital emergency department personnel for Medicaid recipients requiring assessment outside their network areas. If treatment is medically necessary (as defined in item #9 below) outside the network area, the BHO will negotiate a single-case agreement or other non-network arrangement with a qualified provider to deliver that medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Colorado Medicaid Community Mental Health Services Program; and, evidence that the referring symptoms are associated with that covered mental illness, that treatment of the symptoms is medically necessary, and that it is provided within the least restrictive environment. The HCPF document, labeled "Exhibit D1 Covered Mental Health Diagnoses" from the FY10 BHO contract accompanies this document and is available from HCPF or any BHO.

10. Services may be authorized either in whole or in part based upon the relative contribution of covered and non-covered (DD and/or organic brain pathology) conditions, and any collaborative arrangements in place between the BHO and the CCB involved with the individual.

11. At the time of evaluation, the BHO will review all relevant and available information including records of past diagnoses and treatments; however, the BHO will evaluate the provider's diagnostic formulation based on the preponderance of the medical evidence available at the time. If there is not adequate evidence available upon which to accept or challenge the diagnostic formulation of the provider, the BHO may defer its final authorization decision until sufficient information has been received. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

12. Cases in which the BHO evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary, the consumer, family member, CCB Case Manager and/or authorized representative will be given detailed written information, in accordance with HIPAA regulations, about the clinical rationale for the denial as well as information about all available appeal rights and assistance with filing an appeal through the BHO.

14. The BHOs acknowledge that diagnosis often "evolves" over a period of time as the natural progression of a disorder further defines itself ; and, as new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In all situations in which the provider changes a previous diagnostic formulation, they will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the BHO Medical Director will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the BHO contract is the DSM-IV criteria for that diagnosis. BHOs follow conventional diagnostic practice in considering whether DSM-IV criteria are met, and consider that DSM-IV symptomatology may present atypically in individuals with a developmental

disability. However, a DSM-IV diagnosis cannot be made in the absence of reasonably meeting such criteria in the context of an atypical presentation. Diagnostic evaluations will include a review of prior treatment and evaluations, past and current response to prescribed medications, and past and current behavioral presentation as described by care providers, family members and other information sources.

2. Other diagnoses, including the developmental disability, must be present to explain variances from DSM-IV criteria.

3. Consideration is given to the consumer's abilities or disabilities in how DSM-IV criteria present themselves. The diagnostic process must be developmentally sensitive.
4. Additional diagnoses will not be considered in authorizing services when other known and clearly documented diagnoses sufficiently explain the clinical presentation of the consumer.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the consumer, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the consumer, and are provided in the least restrictive setting where services can safely be provided.

7. BHO Medicaid recipients with developmental disability have access to the full spectrum of appeal rights under the Colorado Medicaid Community Mental Health Services Program for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary.

EXHIBIT K, WRAP AROUND SERVICES

I. Wrap Around Services

Wrap Around Services include, but are not limited to, the following:

I.A. Home and Community Based Services Waiver Programs

I.A.1. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD). See 10 CCR 2505-10, Section 8. 485.

I.A.2. Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA). See 10 CCR 2505-10, Section 8. 496.

I.A.3. Home and Community Based Services for the Developmentally Disabled (HCB-DD) Waiver. See 10 CCR 2505-10, Section 8. 500.

I.A.4. Supported Living Services Waiver. See 10 CCR 2505-10, Section 8. 500.90.

I.A.5. Children's Extensive Support Waiver Program (CES). See 10 CCR 2505-10, Section 8. 503.

I.A.6. Home and Community Based Services Pediatric Hospice Waiver. See 10 CCR 2505-10, Section 8. 504.

I.A.7. Children's Home and Community Based Services Waiver Program. See 10 CCR 2505-10, Section 8. 506.

I.A.8. Children's Habilitation Residential Program. See 10 CCR 2505-10, Section 8. 508.

I.A.9. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS). See 10 CCR 2505-10, Section 8. 509.

I.A.10. Consumer Directed Attendant Support Services. See 10 CCR 2505-10, Section 8. 510.

I.A.11. Home and Community Based Services for People with Brain Injury (HCBS-BI). See 10 CCR 2505-10, Section 8. 515.

I.A.12. Consumer Directed Care for the Elderly. See 10 CCR 2505-10, Section 8. 518.

I.A.13. Home and Community Based Services for Children with Autism Waiver. See 10 CCR 2505-10, Section 8. 519

I.A.14. Consumer Directed Attendant Support. See 10 CCR 2505-10, Section 8. 551. Services include skilled nursing services and home health aide services, personal care services and homemaker services.

I.A.15. In-Home Support Services. See 10 CCR 2505-10, Section 8. 552.

I.A.16. Community Transition Services. See 10 CCR 2505-10, Section 8. 553. This is a Single Entry Point agency program.

I.B. Hospice

Hospice entities retain professional, financial, and administrative responsibility for core hospice services.

I.C. Skilled Nursing Facility (Long Term)

Skilled nursing facilities retain professional, financial, and administrative responsibility for core Skilled Nursing Facility Services provided to Members in custodial care.

I.D. Home Health Services (Long Term)

Includes skilled nursing services, home health aide services, occupational therapy services, physical therapy services, and speech/language pathology services for chronic conditions. See 10 CCR 2505-10, Section 8.520.

I.E. Alternative Care Facility Services

See 10 CCR 2505-10, Section 8. 495.

I.F. Non-emergency transportation to medical appointments

Services are provided through the Member's county of residence.

I.G. Food and Lodging to Obtain Out-of-State Medical Services

I.H. Private duty nursing

See 10 CCR 2505-10, Section 8. 540.

I.I. Environmental Modifications

Home modifications and other items listed in 10 CCR 2505-10, Section 8. 516.

I.J. Non-medical Transportation

See 10 CCR 2505-10, Section 8.516.20 and Section 8.494.

I.K. Transitional Living

See 10 CCR 2505-10, Section 8. 516.30.

I.L. Behavioral Programming

See 10 CCR 2505-10, Section 8. 516.40

I.M. Electronic monitoring

See 10 CCR 2505-10, Section 8.488.10.

I.N. Personal Care Services

See 10 CCR 2505-10, Section 8. 489

I.O. Homemaker Services

I.O.1. Homemaker Services are available to clients in the Home and Community Based Services waivers for Elderly Blind and Disabled, Persons Living with Aids and Persons with Mental Illness.

I.O.2. Homemaker Services are available to clients in the Home and Community Based Services waiver for Persons with Brain Injury when the client is also receiving personal care services.

I.P. Adult Day Care Services

See 10 CCR 2505-10, Section 8. 491.

I.Q. Respite Care

See 10 CCR 2505-10, Section 8. 492.

I.R. Home Modifications

See 10 CCR 2505-10, Section 8.493.

I.S. Targeted Case Management Services for Persons with Developmental Disabilities

I.S.1. See 10 CCR 2505-10, Section 8.760

I.S.2. "Targeted Case Management services for persons with developmental disabilities" consist of at least one activity every other month, by the community centered board which is providing targeted case management services to the individual, for one or more of the following purposes:

I.S.2.a. Coordinating the completion of assessments for the determination of the need for services;

I.S.2.b. Facilitating the development of the Individual Habilitation Plan (IMP) and ensuring the development of related Individual Program Plans (IPP);

I.S.2.c. Monitoring and reviewing the goals and services identified in the Individual Habilitation Plan and individual program plans developed in response to the IHP;

I.S.2.d. Coordinating the services being provided as identified in the IHP to ensure continuity of service provision;

I.S.2.e. Advocating for the entry of persons receiving services into the services and/or programs identified in the IHP;

I.S.2.f. Providing counsel and support to the person receiving services and other appropriate parties as necessary to prepare them for entry, transfer or termination from a program;

I.S.2.g. Providing notification and documentation of intended actions, transfers or terminations; or,

I.S.2.h. For persons who no longer require services from the developmental disabilities system or whose needs would be better served in alternative

services options, terminating services or transferring to other necessary services.

I.T. Nurse Home Visitor Program

Nurse Home Visitor Program (NHVP) means a program established pursuant to §25-31-101,C.R.S. et seq., including the provision of targeted case management services to first-time pregnant women or whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level. Services are offered through the child's second birthday plus one month.

I.U. Prenatal Plus Program

I.U.1. Prenatal Plus Program Services address the psychosocial behaviors that impact pregnancy outcome and are in addition to medical prenatal care. They are limited to:

I.U.2. Risk Assessment: Identification and documentation of client medical, psychosocial, nutritional and behavioral strengths and risk factors that could negatively impact pregnancy outcome.

I.U.3. Prenatal Care Coordination: Services provided by a Prenatal Plus provider that includes service planning and coordination, referral, follow-up and monitoring.

I.U.4. Home visitation: A 30-90 minute face-to-face contact with a client at the client's residence or alternative non-provider site by the Prenatal Plus provider to address issues identified through the Risk Assessment.

I.U.5. Nutrition counseling: Nutrition intervention services provided by a registered dietitian including ongoing nutrition assessment, client counseling and referral to other health professionals as needed.

I.U.6. Psychosocial counseling: Services provided by a mental health professional including ongoing assessment of the client's psychological and social situation, brief psychotherapy, crisis intervention and referral to additional mental health treatment as needed.

I.V. Outpatient Substance Abuse Treatment

See 10 CCR 2505-10, Section 8.746, unless the Department exercises its option to include these services in the Program.

I.W. Drug/Alcohol Treatment for pregnant women

Drug/Alcohol Treatment for pregnant women is available through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. See 10 CCR 2505-10, Section 8.745.

I.X. Teen Pregnancy Prevention Services

I.X.1. Teen Pregnancy Prevention Services are a package of support services developed to reduce teen pregnancy including:

I.X.1.a. Intensive individual or group counseling, which includes a component on delayed parenting.

I.X.1.b. Guidance promoting self-sufficiency, self-reliance and the ability to make

appropriate family planning decisions.

I.X.1.c. Home visits or visiting nurse services.

I.X.2. Eligible individuals up to nineteen years of age who reside in a neighborhood in which there is a preponderance of poverty, unemployment and underemployment, substance abuse, crime, school dropouts, a significant public assistance population, teen pregnancies and teen parents or other conditions that put families at risk.