Contract Routing Number 14-56326

CONTRACT AMENDMENT NO. 04

Original Contract Routing Number 3211-0174, CMS 31856

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Community Health Partnership, 722 S. Wahsatch, Colorado Springs, Colorado, 80903, (hereinafter called "Contractor"), and the STATE OF COLORADO, acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called "Department" or "State.")

2. EFFECTIVE DATE AND ENFORCEABILITY

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

3. FACTUAL RECITALS

The Parties entered into the Contract to act as a Regional Care Collaborative Organization for the Department in the Contractor's Region, as that region is defined in Exhibit A-2, Statement of Work. The purpose of this Amendment is to update the Statement of Work to adjust the Contractor's duties and renew the contract for one additional year..

4. CONSIDERATION

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

5. LIMITS OF EFFECT

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

6. MODIFICATIONS

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

A. Section 4. Definitions, Subsection B. Exhibits and other Attachments, is hereby deleted in its entirety and replaced with the following:

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

HIPAA Business Associate Addendum
Exhibit A-3, Statement of Work

Exhibit B, PCMP Requirements
Exhibit C, Member Rights and Protections
Exhibit D, Eligible Member Categories
Exhibit E, Deliverables

B. Section 5, Term and Early Termination, Subsection A, Initial Term-Work Commencement, is hereby deleted in its entirety and replaced with the following:

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

C. Section 20, General Provisions, Subsection I, Order of Precedence, is hereby deleted in its entirety and replaced with the following:

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 B**, PCMP Requirements
vi. **Exhibit C**, Member Rights and Protections
vii. **Exhibit D**, Eligible Member Categories
viii. **Exhibit E**, Deliverables

D. Exhibit A-2, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit A-3, Statement of Work, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit A, A-1, or A-2 shall be deemed to reference to Exhibit A-3.

E. Exhibit E, Deliverables, attached hereto and incorporated by reference, is hereby added to the Contract.

7. START DATE

This Amendment shall take effect on the later of its Effective Date or July 1, 2013

8. ORDER OF PRECEDENCE

Except for the Special Provisions and the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this

Amendment and any of the provisions of the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The most recent version of the Special Provisions incorporated into the Contract or any amendment shall always control other provisions in the Contract or any amendments.

9. AVAILABLE FUNDS

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

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THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

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

CONTRACTOR:
Community Health Partnership

By: _____
Signature of Authorized Officer

Date: June 3, 2013

Carol Bruce-Fritz
Printed Name of Authorized Officer

Executive Director
Printed Title of Authorized Officer

STATE OF COLORADO:
John W. Hickenlooper, Governor

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

Date: 6/11/13

LEGAL REVIEW:
John W. Suthers, Attorney General

By: N/A

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: 6/18/13

EXHIBIT A-3
STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ACRONYMS, ABBREVIATIONS AND DEFINITIONS

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

1.1.1.1. ACC – Accountable Care Collaborative.

1.1.1.2. ACC Program – The Department program designed to affordably optimize Client health, functioning and self-sufficiency with the primary goals to improve Medicaid Client health outcomes and control costs.

1.1.1.3. AwDC – Adults without Dependent Children as defined in CRS §25.5-4-402.3.

1.1.1.4. BHO – Behavioral Health Organization.

1.1.1.5. C.C.R. – Colorado Code of Regulations.

1.1.1.6. CFR – Code of Federal Regulations.

1.1.1.7. Chief Medical Officer – The position within the Contractor's organization responsible for the implementation of all clinical and/or medical programs.

1.1.1.8. Client – An individual eligible for and enrolled in the Colorado Medicaid Program.

1.1.1.9. Contract Manager – The position within the Contractor's organization that acts as the primary point of contact between the Contractor and the Department.

1.1.1.10. Contractor's PCMP Network – All of the providers who have contracted with the Contractor to provide primary care medical home services within the Contractor's Region or to provide primary care medical home services to Members enrolled with the Contractor.

1.1.1.11. Contractor's Region – The region in which the Contractor operates, in the case of this Contract, Region #7.

1.1.1.12. Covered Services – Medicaid benefits according to the Department's State Plan, as filed with the federal Centers for Medicare and Medicaid Services, which are provided through billing manuals and provider bulletins.

1.1.1.13. CRS – Colorado Revised Statutes.

1.1.1.14. EPSDT – Early Periodic Screening, Diagnosis and Treatment.

1.1.1.15. Essential Community Provider – A provider defined under CRS §25.5-5-403.

1.1.1.16. Expansion Phase – The period of time from the end of the Initial Phase until termination of the Contract.

1.1.1.17. Federally Qualified Health Center – A provider defined under 10 C.C.R. 2505-10 §8.700.1.

1.1.1.18. Financial Manager – The position within the Contractor's organization that is responsible for the implementation and oversight of all of the Contractor's financial operations.

1.1.1.19. FQHC – Federally Qualified Health Center.

1.1.1.20. Go-Live Date – June 1, 2011, or the date, upon which the Department gives approval for the Contractor to begin the Initial Phase, whichever is later.

1.1.1.21. Informal Network – The non-contractual or contractual relationships with Providers, other than PCMPs, designed to meet Member's needs.

1.1.1.22. Initial Phase – The period of time from the Go-Live Date until June 30, 2012 or until the Contractor is authorized by the Department to enter the Expansion Phase, whichever is later.

1.1.1.23. Key Personnel – The individuals fulfilling the positions of Contract Manager, Financial Manager or Chief Medical Officer.

1.1.1.24. Marketing Activities – Any activity defined in 42 CFR 438.104.

1.1.1.25. Medical Home – An approach to providing comprehensive primary-care that facilitates partnerships between individual patients, their providers, and, where appropriate, the patient's family, that meets the requirements described in **Exhibit B**, Medical Home Model Principles.

1.1.1.26. Member – Any individual Client who is enrolled with the Contractor or another RCCO.

1.1.1.27. MMIS – the Colorado Medicaid Management Information System.

1.1.1.28. PCCM – Primary Care Case Manager

1.1.1.29. Primary Care Case Manager – A physician, a physician group practice, a physician assistant, nurse practitioner, certified nurse-midwife or entity that employs or arranges with providers to furnish primary care case management services or as described 42 CFR 438.2.

1.1.1.30. Primary Care Medical Provider – A primary care provider who serves as a Medical Home for Members. A PCMP may be a FQHC, RHC, clinic or other group practice that provides the majority of a Member's comprehensive primary, preventive and sick care. A PCMP may also be individual or pods of PCMPs that are physicians, advanced practice nurses or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

1.1.1.31. PCMP – Primary Care Medical Provider.

1.1.1.32. PIP – Performance Improvement Plan.

1.1.1.33. PMPM – Per Member Per Month.

1.1.1.34. RCCO – Regional Care Collaborative Organization.

1.1.1.35. Region – A geographical area containing specific counties, within the State of Colorado, that is served by a RCCO.

1.1.1.36. Region #7 – The geographical area encompassing El Paso, Elbert, Park and Teller Counties.

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

1.1.1.38. RHC – Rural Health Clinic.

1.1.1.39. Rural Health Clinic – A provider or practice as defined in 10 C.C.R. 2505-10 §8.740.

1.1.1.40. SDAC – Statewide Data Analytics Contractor.

1.1.1.41. Start-Up Phase – The period of time from the Contract's Effective Date until the Go-Live Date.

1.1.1.42. STD – Sexually Transmitted Disease.

SECTION 2.0 REGION AND PERSONNEL

2.1. REGION

2.1.1. The Contractor shall be the RCCO for Region #7 and shall be a Primary Care Case Manager (PCCM), as defined in 42 CFR §438.2, for Members enrolled with the Contractor. Region #7 includes El Paso, Elbert, Park and Teller Counties.

2.2. PERSONNEL

2.2.1. The Contractor shall possess the corporate resources and structure necessary to perform its responsibilities under the Contract and successfully implement and operate the Accountable Care Collaborative (ACC) Program in the Contractor's Region.

2.2.2. The Contractor shall provide the following positions, defined as Key Personnel, in relation to the Contract:

2.2.2.1. Contract Manager

2.2.2.1.1. The Contract Manager shall be the Department's primary point of contact for Contract and performance issues and responsibilities.

2.2.2.1.2. All communication between the Department and the Contractor shall be facilitated by the Contract Manager.

2.2.2.1.3. The Contract Manager shall ensure that all Contract obligations are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.

2.2.2.2. Financial Manager

2.2.2.2.1. The Financial Manager shall be responsible for the implementation and oversight of the budget, accounting systems and all other financial operations of the Contractor.

2.2.2.2.2. The Financial Manager shall ensure that all financial operations of the Contractor are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.

2.2.2.3. Chief Medical Officer

2.2.2.3.1. The Chief Medical Officer shall be a physician licensed by the State of Colorado and certified by the Colorado Board of Medical Examiners.

2.2.2.3.2. The Chief Medical Officer shall be responsible for the implementation of all clinical and/or medical programs implemented by the Contractor.

2.2.2.3.3. The Chief Medical Officer shall ensure that all clinical and/or medical programs implemented by the Contractor are implemented and operated in compliance with all

state and federal laws, regulations policies and procedures and with the requirements of the Contract.

2.2.3. Each Key Personnel position shall be filled by separate and distinct individuals. No individual shall be allowed to fulfill multiple Key Personnel positions simultaneously.

2.2.4. The Contract Manager shall perform their responsibilities out of an office that is either located within the Contractor's Region or located in the Denver metro area.

2.2.5. Other Staff Functions

2.2.5.1. The Contractor shall provide staff necessary to ensure that the following functions are performed, in addition to those of the Key Personnel:

2.2.5.1.1. Outcomes and Performance Improvement Management, including overseeing Member and administrative outcomes, coordinating quality improvement activities across the Contractor's Region, benchmarking performance against other Regional Care Collaborative Organizations (RCCOs), ensuring alignment with federal and state guidelines, and setting internal performance goals and objectives.

2.2.5.1.2. Medical Management and Care Coordination Activities, including overseeing medical management and care coordination activities to assist providers and Members in rendering and accessing necessary and appropriate services and resources.

2.2.5.1.3. Communications Management, including organizing, developing, modifying and disseminating information, by way of written material and forums, to providers and Members.

2.2.5.1.4. Provider Relations and Network Management, including establishing agreements with Primary Care Medical Providers (PCMPs), establishing all other formal and informal relationships with providers, provider education, data-sharing, and addressing providers' questions and concerns.

2.2.6. The Contractor shall provide a staff person to be a member of a Department sponsored workgroup on AwDC issues.

2.2.7. The Contractor shall maintain an office in the Contractor's Region and shall make Key Personnel, and other personnel requested by the Department, available for meetings in locations within the State of Colorado, at the Department's request.

2.2.8. The Contractor shall provide the Department with an organizational chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure and the names of the individuals fulfilling each position, within thirty (30) days of the Contract's Effective Date. The organizational chart shall contain accurate and up-to-date telephone numbers and email addresses for each individual listed.

2.2.8.1. DELIVERABLE: Organizational Chart.

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

2.2.9. Contractor shall provide the Department with the opportunity to approve new Key Personnel working on the Contract. Any new Key Personnel shall have, at a minimum, the same qualifications as the individual previously fulfilling that position. The Contractor shall deliver an updated Organizational Chart within five (5) days of any change in Key Personnel or request from the Department for an updated Organizational Chart. The Contractor shall deliver

to the Department an interim plan for fulfilling any vacant position's responsibilities and the plan for filling the vacancy.

2.2.9.1. DELIVERABLE: Updated Organizational Chart.

2.2.9.2. DUE: Five (5) days from any change in Key Personnel of from the Department's request for an updated Organizational Chart.

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

2.2.11. The Department may request the removal from Work on the Contract of employees or agents of the Contractor whom the Department justifies as being incompetent, careless, insubordinate, unsuitable or otherwise unacceptable, or who's continued employment on the Contract the Department deems to be contrary to the public interest or not in the best interest of the Department. For any requested removal of Key Personnel, the Department shall provide written notice to Contractor identifying each element of dissatisfaction with each Key Personnel, and Contractor shall have ten (10) business days from receipt of such written notice to provide the Department with a written action plan to remedy each stated point of dissatisfaction. Contractor's written action plan may or may not include the removal of Key Personnel from Work on the Contract.

SECTION 3.0 MEMBERSHIP, ENROLLMENT AND CLIENT CONTACT

3.1. MEMBERSHIP AND ENROLLMENT

3.1.1. Enrollment and PCMP Selection

3.1.1.1. The Department will enroll Clients with the Contractor based on the Department's enrollment and reenrollment procedures. The Contractor shall accept all Clients, that the Department enrolls, that are eligible for enrollment. The Contractor shall accept individuals eligible for enrollment in the ACC Program in the order in which they are passively enrolled or apply without restriction. The Department may enroll any Client who is included in any of the eligibility categories shown in **Exhibit D**, Eligible Member Categories.

3.1.1.2. Members who are eligible through AwDC are mandatorily enrolled in the ACC Program.

3.1.1.3. Each Member shall have the option to select a PCMP to provide comprehensive primary-care to the Member and a majority of all of the Member's medical care. If a Member has not selected a PCMP prior to the Member's enrollment, the Contractor shall attempt to contact the Member and assist the Member in selecting a PCMP. The Contractor shall make a minimum of two attempts to contact the Member, using different methods, if needed. The Contractor shall, on at least a quarterly basis, identify and implement strategies to reach Members whose phone or address information is incorrect. The Contractor shall develop specific strategies for reaching AwDC members. Once the Contractor has contacted the Member, it shall provide the Member with contact information for available geographically appropriate PCMPs who are enrolling new Members in the Member's Region and assist the Member in selecting a PCMP. The Contractor may act as a liaison between the Member and any PCMP the Member wishes to select. The Contractor shall document all attempts at contacting Members who have not selected a PCMP and the results of each attempt. The Contractor shall maintain a record of all attempts made to contact a Member.

3.1.1.3.1. The Department shall provide the Contractor with a Member eligibility report and a Member eligibility change report, on a monthly basis. The Member eligibility report shall contain the PCMP selected by each Member in the Contractor's Region and the applicable demographics for each Member. The Member change report shall show any additions, deletions or changes to the existing PCMP selection records.

3.1.1.3.2. The Contractor shall provide the results of the attempts to contact Members who have not selected a PCMP during the calendar quarter in the Stakeholder Report. The report shall also contain a plan for the following calendar quarter regarding Member contact and how the Contractor will resolve any deficiencies identified during the prior quarter.

3.1.1.4. Members have the option to select PCMP or receive care within a Region other than the one in which they reside. In the event that a Member within Contractor's Region selects a PCMP or selects to receive care within another RCCO's Region, the Contractor shall coordinate with the other RCCO to ensure that the Member's quality, quantity and timeliness of care are not affected by the Member's choice.

3.1.1.4.1. The Department and Contractor shall work together to implement a report that will alert the Contractor when a Member in the Contractor's Region selects a PCMP in another Region so that the Contractor may coordinate with that other Region's RCCO.

3.1.1.5. The Contractor shall coordinate with any other RCCO, in the event that a Member residing within the other RCCO's Region selects a PCMP or selects to receive care within the Contractor's Region, to ensure that the Member's quality, quantity and timeliness of care are not affected by the Member's choice.

3.1.1.6. The Contractor shall only accept Members who reside within their Region and who reside sufficiently near the office of a PCMP in the Contractor's network for the Member to reach that PCMP within a reasonable time and using available and affordable modes of transportation.

3.1.1.7. The Contractor shall not discriminate against individuals eligible to enroll in the ACC Program on the basis of race, color or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

3.1.1.8. The Department will provide the Contractor with the following reports, from the Colorado MMIS Medicaid Management Information System (MMIS), for the Contractor to verify Member eligibility and enrollment:

3.1.1.8.1. Daily Disenrollment.

3.1.1.8.2. Monthly Enrollment Change.

3.1.1.8.3. Monthly Report of All Enrollees.

3.1.1.8.4. Daily New Enrollees.

3.1.1.8.5. Monthly Disenrollments.

3.1.1.8.6. Monthly New Enrollees.

3.1.1.8.7. X12 transaction reports, including:

3.1.1.8.7.1. Client Capitations.

3.1.1.8.7.2. Benefit Enrollment and Maintenance.

3.1.1.8.7.3. Eligibility Response.

3.1.1.8.7.4. Acknowledgment of a sent transaction.

3.1.1.8.8. Managed Care Transaction Report.

3.1.1.8.9. Monthly ACC Roster Report.

3.1.2. Disenrollment

3.1.2.1. Contractor may only request disenrollment of a Member from the ACC Program for cause. The Department shall review the Contractor's requests for disenrollment and may grant or reject the Contractor's request at its discretion. A disenrollment for cause may only occur under the following circumstances:

3.1.2.1.1. The Member moves out of the Contractor's Region.

3.1.2.1.2. The Contractor's plan does not, because of moral or religious reasons, cover the service the Member seeks.

3.1.2.1.3. The Member needs related services to be performed at the same time, not all related services are available within the network and the Member's PCMP or another provider determines that receiving the services separately would subject the Member to unnecessary risk.

3.1.2.1.4. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Member's health care needs.

3.1.2.1.5. Abuse or intentional misconduct consisting of any of the following:

3.1.2.1.5.1. Behavior of the Member that is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired.

3.1.2.1.5.2. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.

3.1.2.1.5.3. Behavior of the Member that poses a physical threat to the provider, to other providers, Contractor or PCMP staff or to other Members.

3.1.2.1.5.4. The Contractor shall provide one oral warning to any Member exhibiting abusive behavior or intentional misconduct, stating that continuation of the behavior or misconduct will result in a request for disenrollment. If the Member continues the behavior or misconduct after the oral warning, the Contractor shall send a written warning that the continuation of the behavior or misconduct will result in disenrollment from the Contractor's plan. The Contractor shall send a copy of the written warning and a written report of its investigation into the behavior to the Department no less than thirty (30) days prior to the disenrollment. If the Member's behavior or misconduct poses an imminent threat to the provider, to other providers, Contractor or PCMP staff or to other Members, the Contractor may request an expedited disenrollment after it has provided the Member exhibiting the behavior or misconduct an oral warning.

3.1.2.1.5.4.1. DELIVERABLE: Written warning and written report of abusive behavior or intentional misconduct.

3.1.2.1.5.4.2. DUE: No less than thirty (30) days prior to disenrollment unless the Department approves expedited disenrollment.

3.1.2.1.6. The Member commits fraud or knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor as part of the Member's enrollment in the Contractor's plan.

3.1.2.1.7. Any other reason determined to be acceptable by the Department.

3.1.2.2. Disenrollment for cause shall not include disenrollment because of:

3.1.2.2.1. Adverse changes in the Member's health status.

3.1.2.2.2. Change in the Member's utilization of medical services.

3.1.2.2.3. The Member's diminished mental capacity.

3.1.2.2.4. Any behavior of the Member resulting from the Member's special needs, as determined by the Department, unless those behaviors seriously impair the Contractor's ability to furnish services to that Member or other Members.

3.1.2.2.5. Receipt of Medicare coverage at any time following the end of the Initial Phase.

3.1.2.3. The Department may select to disenroll any Member at the Department's sole discretion. If the Department selects to disenroll a Member, the Department may reenroll that same Member with the Contractor at any time or with any other RCCO if the Member now resides within that other RCCO's Region.

3.1.2.4. The Department may disenroll any Member, who requests disenrollment, in its sole discretion.

3.1.2.5. The Department may disenroll a Member from the ACC Program upon that Member's request. A Member may request disenrollment, and the Department may grant the Member's request:

3.1.2.5.1. For cause, at any time. A disenrollment for cause may occur under the following circumstances:

3.1.2.5.1.1. The Member moves out of the Contractor's service area.

3.1.2.5.1.2. The Contractor does not, because of moral or religious objections, cover the service the Member needs.

3.1.2.5.1.3. The Member needs related services (for example, a caesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network and the Member's PCMP or another physician determines that receiving the services separately would subject the Member to unnecessary risk.

3.1.2.5.1.4. Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error.

3.1.2.5.1.5. Poor quality of care, as documented by the Department.

3.1.2.5.1.6. Lack of access to covered services, as documented by the Department.

3.1.2.5.1.7. Lack of access to Providers experienced in dealing with the Member's health care needs.

3.1.2.5.2. Without cause, at any time during the ninety (90) days following the date of the Member's initial enrollment with the Contractor.

3.1.2.5.2.1. A Member may request disenrollment, without cause, at least once every twelve (12) months after the first ninety (90) day period.

3.1.2.5.2.2. A Member may request disenrollment, without cause, upon automatic reenrollment under 42 CFR 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

3.1.2.6. The Department may reenroll with the Contractor any Member who was disenrolled solely because the Member lost eligibility for Medicaid benefits and the loss was for a period of sixty (60) days or less.

3.1.2.7. In the event that the Department grants a request for disenrollment, either from the Contractor or from a Member, the effective date of that disenrollment shall be no later than the first day of the second month following the month in which the Member or Contractor files the request. If the Department fails to either approve or deny the request in this timeframe, the request shall be considered approved.

3.1.2.8. The Contractor shall have written policies that comply with the requirements of **Exhibit C**, Member Rights and Protections.

3.1.2.9. The Contractor shall ensure that PCMPs are in compliance with federal regulations regarding client dismissal.

3.2. CLIENT CONTACT RESPONSIBILITIES

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

3.2.1.1. All materials shall be written in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438. The Contractor shall notify all Members and potential Members of the availability of alternate formats for the information, as required by 42 CFR 438.10, and how to access such information.

3.2.1.2. All materials shall be written in easy to understand language and shall comply with all applicable requirements of 42 CFR 438.10.

3.2.1.3. The Contractor shall submit all materials to the Department at least ten (10) Business Days prior to the Contractor printing or disseminating such materials to any Member or Client, unless the Department approves a shorter submission deadline. The Department may review any materials and reserves the right to require changes or redrafting of the document as the Department determines necessary to ensure that the language is easy to understand. The Contractor shall make any required changes to the materials. Once a change is made to the materials, the Contractor shall not use any prior versions of the materials in any distribution to any Client or Member, unless the Department gives express written consent. This submission requirement shall not apply to items that are directed toward and addressed to individual Members.

3.2.1.3.1. DELIVERABLE: Updated client materials including changes required by the Department.

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

3.2.2. The Contractor shall assist any RCCO member who contacts the Contractor, including RCCO members not in the Contractor's region who need assistance with contracting his/her PCMP and/or RCCO. The Department will provide data to the RCCO on all ACC members for this

purpose. If the member does not have a PCMP, the Contractor shall assist the client in identifying a PCMP and making that selection with the enrollment broker.

3.2.3. The Contractor shall create the following materials during the Start-Up Phase:

3.2.3.1. A section of the Department's ACC Program Member Handbook, that describes the Contractor's roles, responsibilities and functions that support the ACC Program, how to access the Contractor's care coordination services and relevant telephone numbers and website addresses. The information in this section shall be specific to the Contractor's Region.

3.2.3.1.1. DELIVERABLES: ACC Program Member Handbook section specific to the Contractor's Region.

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

3.2.3.1.3. DELIVERABLES: ACC Program Member Handbook - updated section specific to the Contractor's Region, when significant changes occur.

3.2.3.1.4. DUE: Thirty (30) days from the effective date of the changes.

3.2.3.2. A Directory of PCMPs.

3.2.3.2.1. DELIVERABLES: PCMP Directory.

3.2.3.2.2. DUE: by the Go-Live Date and monthly by the first day of the month, unless extension is allowed by the Department.

3.2.4. Marketing

3.2.4.1. The Contractor shall not engage in any Marketing Activities, as defined in 42 CFR 438.104, during the Start-Up Phase or the Initial Phase.

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

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

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

3.2.4.2.3. The Contractor shall distribute the materials to the entire service area.

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

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

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

3.2.4.2.7. Marketing Materials shall not contain any assertion or statement, whether written or oral, that the Contractor is endorsed by the Centers for Medicare and Medicaid Services, the Federal or State government or similar entity.

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

3.2.5. Upon termination of a PCMP's agreement or participation with the Contractor, for any reason, the Contractor shall notify any Member, who has selected that PCMP, of that PCMP's termination, as required in 42 CFR 438.10(f)(5).

3.2.5.1. DELIVERABLE: Notice to Members of PCMP termination.

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

3.2.6. The Contractor shall conduct ongoing Member satisfaction surveys that include, but are not limited to, how the individual was treated, adequacy of information provided regarding that treatment and plan of care, cleanliness of service environment, billing efficiency, ease of parking and length of wait time.

3.2.7. The Contractor shall communicate with Members on a quarterly basis regarding the ACC program, plan benefits, highlights of program changes, upcoming Local Advisory Committee meetings and other health and wellness information. The Contractor may trial different communication methods and build a plan that maximizes the most effective methods of communication.

SECTION 4.0 NETWORK STRATEGY

4.1. PCMP NETWORK AND NETWORK DEVELOPMENT

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

4.1.2. The Contractor shall document its relationship with and requirements for each PCMP in the Contractor's PCMP Network in a written contract with that PCMP.

4.1.3. The Contractor shall only enter into written contracts with PCMPs that meet the following criteria:

4.1.3.1. The PCMP practice and the individual PCMP are enrolled as a Colorado Medicaid provider.

4.1.3.2. The PCMP practice and the individual PCMP, as applicable, are currently licensed by the Colorado Board of Nursing or Board of Medical Examiners to practice medicine in the State of Colorado.

4.1.3.3. The individual PCMP shall act as the primary care provider for a Member and is capable of providing a majority of that Member's comprehensive primary, preventative and urgent or sick care.

4.1.3.4. The PCMP practice is certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children Program or the PCMP practice is a Federally Qualified Health

Center, a Rural Health Clinic, clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

4.1.3.5. The Contractor may not prohibit a PCMP from entering into a contract with another RCCO.

4.1.4. The Contractor shall ensure that its PCMP network is sufficient to meet the requirements for every Member's Access to Care, to serve all Member's primary care needs and allow for adequate Member freedom of choice amongst PCMPs and providers during the Initial Phase and Expansion Phase.

4.1.5. The Contractor's network shall include Essential Community Providers and private for-profit and not-for-profit providers.

4.1.6. The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include, but are not limited to:

4.1.6.1. The physically or developmentally disabled.

4.1.6.2. Children and foster children.

4.1.6.3. Adults and the aged.

4.1.6.4. Non-English speakers.

4.1.6.5. AwDC expansion population.

4.1.6.6. Members with complex behavioral or physical health needs.

4.1.6.7. Members with Human Immunodeficiency Virus (HIV).

4.1.7. The Contractor's network shall provide the Contractor's Members with a meaningful choice in selecting a PCMP.

4.1.7.1. If a Member within the Contractor's Region selects a provider that has not entered into an agreement with the Contractor or another RCCO, the Contractor shall make an effort to enroll the provider.

4.1.7.1.1. The Contractor shall make an initial contact, through any method allowed by the Department and state and federal statutes, regulations policies or procedures, with the provider to attempt to enroll the provider in the Contractor's network.

4.1.7.1.2. If the Contractor is unsuccessful in its initial contact, then the Contractor shall make one (1) follow-up contact to attempt to enroll the provider in the Contractor's network.

4.1.8. The Contractor shall reasonably ensure that all providers and PCMPs in its network are aware of the requirement for a clinical referral when a Member receives services from another provider.

4.1.9. The Contractor may provide its Members access to all of the following:

4.1.9.1. A mobile clinic offering walk-in care to the homeless Members in the Contractor's Region.

4.1.9.2. A mobile family clinic offering walk-in and scheduled appointments.

4.1.9.3. Twenty-four (24) hour per day nurse triage phone service and rotating on-call providers.

4.1.10. The Contractor shall provide an electronic system to track its relationships with all of its PCMPs and any other provider with whom it has a relationship. This system shall include, but is not limited to, information on provider's contracted services, specialty areas, office hours

and locations. The Contractor shall also use this system to identify deficiencies in the services available within the Contractor's network of providers and to perform the necessary outreach to address those deficiencies.

4.2. ACCESS TO CARE STANDARDS

4.2.1. The Contractor's PCMP Network shall have a sufficient number of PCMPs so that each Member has a PCMP and each Member has their choice of at least two (2) PCMPs within their zip code or within thirty (30) minutes of driving time from their location, whichever area is larger. For rural and frontier areas, the Department may adjust this requirement based on the number and location of available providers.

4.2.1.1. In the event that there are less than two (2) medical providers qualified to be a PCMP within the area defined in the prior paragraph for a specific Member, then the requirements of that paragraph shall not apply to that Member.

4.2.2. The Contractor's PCMP Network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. The Contractor will determine the appropriate requirements for the number of extended hours and weekend availability based on the needs of the Contractor's Region, and submit these requirements to the Department for approval. The Contractor shall assess the needs of the Contractor's Region on a regular basis, no less often than quarterly, and submit a request to the Department to adjust its requirements accordingly.

4.2.2.1. At a minimum, the Contractor's PCMP Network shall provide for twenty-four (24) hour a day availability of information, referral and treatment of emergency medical conditions.

4.2.3. The Contractor shall have a system to track Member access at the PCMP provider level, including requests for same-day care, requests for routine care and how long a Member must wait before an appointment is available. The Contractor shall provide this information in a mutually agreed reporting format and on a mutually agreed schedule.

4.2.4. The Contractor's PCMP Network shall be sufficient to ensure that appointments will be available to all Members:

4.2.4.1. Within forty-eight (48) hours of a Member's request for urgent care.

4.2.4.2. Within ten (10) calendar days of a Member's request for non-urgent, symptomatic care.

4.2.4.3. Within forty-five (45) calendar days of a Member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedules.

4.2.5. The Contractor shall reasonably ensure that Members in the Contractor's Region have access to specialists and other Medicaid providers promptly and without compromising the Member's quality of care or health.

4.2.6. The Department shall reimburse any provider for a Member's emergency services as otherwise authorized by Medicaid regardless of whether the provider that furnished the services has a contract with the Contractor.

4.3. ONGOING NETWORK MANAGEMENT AND REGIONAL STRATEGY

4.3.1. The Contractor shall develop relationships with providers and other community resources in the Contractor's Region. The Contractor shall document its relationships with its informal

network, including document its relationships with its informal network, including those providers and community resources, listing the names of the providers and resources, their area or areas of specialty and any other information requested by the Department. The Contractor shall provide updated documentation of its relationships, at least semiannually, once in December and once in June.

4.3.1.1. DELIVERABLE: Provider and community resource relationship documentation.

4.3.1.2. DUE: Semiannually on January 31st and July 31st.

4.3.2. The Contractor shall create and document a communication plan to communicate with all providers, behavioral health managed care organizations and PCMPs in its network and other community resources with which it has relationships, and to promote communication amongst the providers.

4.3.2.1. The communication plan may include the following methods:

4.3.2.1.1. Assignment of providers to a specific provider relations consultant or point-of-contact within the Contractor's organization.

4.3.2.1.2. Holding information sessions for interested providers at practice association meetings or conferences.

4.3.2.1.3. Providing orientation sessions for providers that are new to the Contractor's network.

4.3.2.1.4. Hosting forums for ongoing training regarding the ACC Program and services the Contractor offers.

4.3.2.1.5. Posting provider tools, trainings, informational material and the Contractor's contact details on the internet in easily accessible formats.

4.3.2.1.6. Developing standard communication intervals at which the Contractor will contact providers to maintain connection and lines of communication.

4.3.2.2. The Contractor shall distribute a network newsletter, on a quarterly basis, with tips and tools to promote continuous provider interest and involvement and includes, at a minimum:

4.3.2.2.1. Policy changes.

4.3.2.2.2. Upcoming training sessions.

4.3.2.2.3. Articles supporting program design for PCMPs in the ACC Program.

4.3.2.3. The Contractor shall submit its initial communication plan for the Department's review. The Contractor shall submit any significant changes to the Communication plan for the Department's review and approval.

4.3.2.3.1. DELIVERABLE: Communication plan.

4.3.2.3.2. DUE: Ten (10) days from the Contract's Effective Date for the initial communication plan and thirty (30) days from the date of any change for an updated communication plan.

4.3.2.4. The Contractor shall submit an annual communication plan for the Department's review. In addition, the Contractor shall submit any significant changes to the Communication plan for the Department's review and approval prior to implementation.

4.3.2.4.1. DELIVERABLE: Annual communication plan.

4.3.2.4.2. DUE: Annually on July 1st and thirty (30) days from the date of any change for an updated communication plan.

4.3.3. The Contractor shall create an expansion plan that will describe how it will expand its network to accommodate the increased Members enrolled during the Expansion Phase. The Contractor shall deliver this expansion plan to the Department within ninety (90) days of the Contract's Effective Date. The Department may direct changes to the plan if it believes the expansion plan is insufficient.

4.3.3.1. DELIVERABLE: Expansion plan.

4.3.3.2. DUE: Ninety (90) days from the Contract's Effective Date.

4.3.4. The Contractor shall perform PCMP and provider satisfaction surveys, on a quarterly basis, to assess the adequacy of support and assistance rendered by the Contractor to providers.

SECTION 5.0 PROVIDER SUPPORT

5.1. ADMINISTRATIVE SUPPORT

5.1.1. The Contractor shall make all of the providers in its network aware of Colorado Medicaid programs, policies and processes within one (1) month of executing a contract with a that provider.

5.1.1.1. This information shall include, but is not limited to, information regarding all of the following:

5.1.1.1.1. Benefit packages and coverage policies.

5.1.1.1.2. Prior authorization referral requirements.

5.1.1.1.3. Claims and billing procedures.

5.1.1.1.4. Eligibility and enrollment processes.

5.1.1.1.5. Other operational components of service delivery.

5.1.1.2. This information shall be delivered to providers during direct contact at meetings, forums, training sessions or seminars, or through any method of mailing, as defined in 10 C.C.R. 2505-10 §8.050.

5.1.1.3. The Contractor shall submit all formal policy and procedure documents and plans for provider support to the Department for review. The Department may request changes to the formal policy and procedure documents or plans for direct contact, and the Contractor shall make the changes and deliver the updated documents or plans to the Department.

5.1.1.3.1. DELIVERABLE: All information documents and direct provider contact plans.

5.1.1.3.2. DUE: Ten (10) days from the date the documents or plans are requested by the Department; and ten (10) days from the request by the Department to make a change for updated documents.

5.1.2. The Contractor shall make informational and educational materials available to providers regarding the roles that the Department, the Contractor and other Department contractors and partners play in the Colorado Medicaid system. These other Department contractors and partners shall include, at a minimum all of the following:

5.1.2.1. The Statewide Data Analytics Contractor (SDAC).

5.1.2.2. The Department's enrollment broker.

5.1.2.3. The State's Medicaid fiscal agent.

5.1.2.4. The Department's utilization management contractor.

5.1.2.5. The Department's managed care ombudsman.

5.1.2.6. The county departments of human and social services for the counties in the Contractor's Region.

5.1.2.7. The Community-Centered Boards and Single Entry Point agencies.

5.1.3. The Contractor shall act as a liaison between the Department and its other contractors and partners and the providers. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:

5.1.3.1. Issues relating to Medicaid provider enrollment.

5.1.3.2. Prior authorization and referral issues.

5.1.3.3. Member eligibility and coverage policies.

5.1.3.4. PCMP designation problems.

5.1.3.5. PCMP Per Member Per Month (PMPM) payments.

5.1.4. The Contractor shall provide a client and provider service center to receive calls from Members and providers regarding the ACC Program and to address all issues or problems facing those Members or providers related to the ACC Program. The Contractor shall make this service center available to clients and providers from 8:00 am until 5:00 pm Mountain Time of each Business Day.

5.1.5. Using the Department provided data on all ACC members, the contractor shall assist all ACC PCMPs (including those they are not contracted with), upon request, by providing information on the provider's ACC members and their member's RCCO assignments.

5.2. PRACTICE SUPPORT

5.2.1. The Contractor shall submit a Practice Support Plan, describing its annual activities, specific efforts to support the integration of behavioral and primary care, and efforts to meet the needs of the AwDC population for Department review and approval. These practice support activities shall be directed at a majority of the PCMPs in the Contractor's Region and may range from disseminating a practice support resource to its PCMP network to conducting formal training classes for PCMPs relating to practice support. These activities shall include at least one activity relating to each of the following topics:

5.2.1.1. Operational practice support.

5.2.1.2. Clinical tools.

5.2.1.3. Client or Member materials.

5.2.1.3.1. DELIVERABLE: Practice Support Plan.

5.2.1.3.2. DUE: Annually, within the first three (3) months of the state fiscal year.

5.2.2. The Department will provide the Contractor materials relating to behavioral health and the BHOs. The Contractor shall distribute these materials to all of the PCMPs in the Contractor's

PCMP Network. The Department will direct the Contractor on the method for distributing these materials.

5.2.3. The Contractor shall offer support to PCMPs and providers, which may include comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities. The Contractor shall provide tools to the PCMPs and providers that may include any of the following:

5.2.3.1. Clinical Tools:

5.2.3.1.1. Clinical care guidelines and best practices.

5.2.3.1.2. Clinical screening tools, such as depression screening tools and substance use screening tools.

5.2.3.1.3. Health and functioning questionnaires.

5.2.3.1.4. Chronic care templates.

5.2.3.1.5. Registries.

5.2.3.2. Client Materials:

5.2.3.2.1. Client reminders.

5.2.3.2.2. Self-management tools.

5.2.3.2.3. Educational materials about specific conditions.

5.2.3.2.4. Client action plans.

5.2.3.2.5. Behavioral health surveys and other self-screening tools.

5.2.3.3. Operational Practice Support:

5.2.3.3.1. Guidance and education on the principles of the Medical Home.

5.2.3.3.2. Training on providing culturally competent care.

5.2.3.3.3. Training to enhance the health care skills and knowledge of supporting staff.

5.2.3.3.4. Guidelines for motivational interviewing.

5.2.3.3.5. Tools and resources for phone call and appointment tracking.

5.2.3.3.6. Tools and resources for tracking labs, referrals and similar items.

5.2.3.3.7. Referral and transitions of care checklists.

5.2.3.3.8. Visit agendas or templates.

5.2.3.3.9. Standing pharmacy order templates.

5.2.3.4. Data, Reports and Other Resources:

5.2.3.4.1. Expanded provider network directory.

5.2.3.4.2. Comprehensive directory of community resources.

5.2.3.4.3. Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line.

5.2.3.4.4. Link from main ACC Program website to the Contractor's website of centrally located tools and resources.

5.2.4. The Contractor shall provide qualified staff to act as transformation coaches for the providers in the Contractor's PCMP Network. The transformation coaches shall provide assistance necessary for the providers to build skills for their medical home practice. The areas that these transformation coaches shall address include, but are not limited to, all of the following:

5.2.4.1. Process mapping.

5.2.4.2. Data analysis.

5.2.4.3. Embedding clinical guidelines.

5.2.4.4. Development of strategies for impacting clinical outcomes.

5.2.4.5. Improving office efficiencies.

5.2.4.6. Tri-annual group learning collaborative with other practices.

5.2.5. Provider Support Accessibility

5.2.5.1. The Contractor shall have an internet-accessible website that contains, at a minimum, all of the following:

5.2.5.1.1. General information about the ACC Program, the Contractor entity, the Contractor's role and purpose and the principles of a Medical Home.

5.2.5.1.2. A network directory listing providers and PCMPs with whom the Contractor has a contract, their contact information and provider characteristics such as gender, languages spoken, whether they are currently accepting new Medicaid clients and links to the provider's website if available.

5.2.5.1.3. A provider page or section that contains a description of the support the Contractor offers to providers, an online library of available tools, screenings, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.

5.2.5.1.4. A listing of immediately available resources to guide providers and their Members to needed community-based services, such as child care, food assistance, services supporting elders, housing, utility assistance and other non-medical supports.

5.2.6. The Contractor shall provide interpreter services for all interactions with Members or Clients when there is no bilingual or multilingual staff member of the Contractor available who speaks a language understood by a Member.

5.2.6.1. The Contractor may provide interpreter services for any PCMP in the Contractor's Region or any other provider with whom the Contractor has an agreement that the provider needs to interact with Members.

5.3. DATA ANALYSIS AND REPORTS

5.3.1. The Contractor shall provide reasonable network and care coordination data to the Department or to the SDAC at the Department's direction.

5.3.2. The Contractor shall access any reports, queries and searches it requires from the SDAC. The Contractor shall design any queries or searches it requires and interpret the results of the queries and searches it conducts.

5.3.2.1. The Contractor shall share with the PCMPs, the SDAC and the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.

5.3.3. The Contractor shall educate and inform the PCMPs and providers about the data reports and systems available to the providers and the practical uses of the available reports.

5.3.4. The Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern and apply the information to make changes and improve the health outcomes of its members.

5.3.4.1. The Department may request that the Contractor report the results of any analysis it performs. At the Department's request, the Contractor shall report the results of the analyses it performed to the Department and what steps it intends to take based on those analyses, within ten (10) days of the Department's request. The Department may request additional information, that the Contractor perform further analyses or that the Contractor modify any steps it intends to take at the Department's sole discretion.

SECTION 6.0 MEDICAL MANAGEMENT AND CARE COORDINATION

6.1. REFERRAL PROCESS ASSISTANCE

6.1.1. The Contractor shall ensure that all PCMPs with which it contracts are aware of and comply with the Department's referral requirements. These requirements include referring the PCMP's Members to specialty care, as appropriate, and ensuring that clinical referrals are completed between PCMPs and specialists/referred providers to facilitate optimal health care, care coordination, and information sharing.

6.1.1.1. The Contractor shall develop a written protocol for clinical referrals to facilitate care coordination and sharing of relevant Member information and deliver those protocols to the Department for review and approval.

6.1.1.1.1. DELIVERABLE: Clinical Referral Protocol.

6.1.1.1.2. DUE: No later than June 30, 2013.

6.1.1.2. The Department will review the Contractor's Clinical Referral Protocol and may direct changes. In the event that the Department directs changes, the Contractor shall make all changes to the Clinical Referral Protocol as directed by the Department.

6.1.1.2.1. DELIVERABLE: Clinical Referral Protocol including all changes directed by the Department.

6.1.1.2.2. DUE: Within three (3) Business Days from the Department's request for a change, unless more time is granted by the Department.

6.1.1.3. The Contractor shall implement the Clinical Referral Protocol upon Department approval.

6.1.1.4. In the event that the Contractor desires to make a material change to its Clinical Referral Protocol, the Contractor shall deliver any updates to its Clinical Referral Protocol to the Department for review and approval.

6.1.1.5. The Contractor shall not implement any material change to the Clinical Referral Protocol or updated Clinical Referral Protocol prior to the Department's approval of that protocol.

6.1.1.6. The Contractors will work with providers and the Department to minimize administration burden on providers resulting from the Contractor's protocols.

6.1.2. The Contractor shall allow the PCMPs with which it contracts to refer Members to any specialists enrolled in Medicaid or any other Medicaid provider, including those not associated with the Contractor or another RCCO. The PCMP will not be required to provide a referral when the Member receives any of the following services:

6.1.2.1. Emergency care.

6.1.2.2. EPSDT screenings.

6.1.2.3. Emergency and non-emergent medical transportation.

6.1.2.4. Anesthesiology services.

6.1.2.5. Dental services.

6.1.2.6. Vision services.

6.1.2.7. Family planning services.

6.1.2.8. Behavioral health services.

6.1.2.9. Home and Community-Based Waiver services, as defined in the State Plan that the Department has submitted to the Centers for Medicare and Medicaid Services.

6.1.2.10. Obstetrical care.

6.1.2.11. Primary care from a primary care physician, other than the Member's PCMP, if the Member's PCMP is unavailable to see the Member.

6.1.2.12. Hospice Care.

6.1.3. After the clinical referral protocol described in section 6.1.1.3 is implemented, the Contractor shall ensure that the goal of improved communication and care coordination is met and that clinical referrals are occurring.

6.1.3.1. The Department may request and review data and supporting documentation from the Contractor to ensure compliance with this requirement. All such monitoring will be performed in a manner that will not unduly interfere with contract work.

6.2. MEDICAL MANAGEMENT SUPPORT

6.2.1. The Contractor shall use, and recommend to PCMPs, traditional and non-traditional medical management practices and tools to ensure optimal health outcomes and manage costs for the Department and the Contractor's Members. These practices and tools may include, but are not limited to, any of the following:

6.2.1.1. Traditional methods:

6.2.1.1.1. Coordination with the Department's utilization management contractor to detect inappropriate utilization of services.

6.2.1.1.2. Integrating disease management into the care of Members with multiple chronic conditions.

6.2.1.1.3. Catastrophic case management.

6.2.1.1.4. Coordination of medical services for Members with serious, life-changing, and possibly life-threatening, illnesses and injuries.

6.2.1.2. Innovative and proven or promising practices:

6.2.1.2.1. Technologically enhanced communication, such as cell phone messages, email communication and text messaging.

6.2.1.2.2. Providing PCMPs with tools and resources to support informed medical decision-making with Members.

6.2.1.2.3. Alternate formats for delivering care.

6.2.1.2.4. Methods for diversion to the most appropriate care setting.

6.2.2. The Department may review the Contractor's medical management practices and tools. In the event that the Department determines any practice or tool to be ineffective, inappropriate or otherwise unacceptable, the Contractor shall cease using or recommending that practice or tool immediately upon notification by the Department of its unacceptability.

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

6.3.1. The Contractor shall promote Member education and informed decision-making regarding healthy lifestyle choices, medical treatment and all aspects of the Member's own health care. This education shall include an overview of the ACC Program and how to navigate services within the Colorado Medicaid program. The Contractor's strategies may include, but are not limited to:

6.3.1.1. A comprehensive approach to promoting healthy behavior that takes into consideration factors that affect healthy behavior, such as community and cultural practices and standards, daily work and life opportunities and limitations and Member awareness of how behavior affects health. This approach may include clinical, personal and community-based strategies, as appropriate.

6.3.1.2. Motivational interviewing to create Member-centered, directive methods for increasing the member's intrinsic motivation to change behavior.

6.3.1.3. Use of member decision aids.

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

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

6.4. CARE COORDINATION

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

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

6.4.2. Regardless of its relationships or contracts with PCMPs or Subcontractors, the Contractor shall:

6.4.2.1. Assess current care coordination services provided of its Members to determine if the providers involved in each Member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided.

6.4.2.2. Provide all care coordination services that are not provided by another source.

6.4.2.3. Work with providers who are responsible for the Member's care to develop a plan for regular communication with the person(s) who are responsible for the Member's care coordination.

6.4.2.4. Reasonably ensure that all care coordination services, including those provided by other individuals or entities, meet the needs of the Member.

6.4.3. The Contractor shall develop a formal system of care coordination for its Members. This formal system shall have the following characteristics:

6.4.3.1. Comprehensive Care Coordination characteristics include:

6.4.3.1.1. Assessing the Member's health and health behavior risks and medical and non-medical needs, including determining if a care plan exists and creating a care plan if one does not exist and is needed.

6.4.3.1.1.1. The care plan shall include a behavioral health component for those clients in need of behavioral health services.

6.4.3.1.2. The ability to link Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports. This ability to link may range from being able to provide Members with the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers and the Member.

6.4.3.1.3. Providing assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. This assistance shall promote continuity of care and prevent unnecessary re-hospitalizations and document and communicate necessary information about the Member to the providers, institutions and individuals involved in the transition.

6.4.3.1.4. Providing solutions to problems encountered by providers or Members in the provision or receipt of care.

6.4.3.1.4.1. The Contractor shall document all problems presented by providers and Members in the provision or receipt of care and the solutions given to the provider or the Member. The Department may review any of the documented solutions and, should the Department determine the solution to be insufficient or otherwise unacceptable, may direct the Contractor to find a different solution or follow a specific course of action.

6.4.3.1.5. Informing the Members of the Department's Medicaid ombudsman to assist the Member in resolving health care issues and filing grievances.

6.4.3.1.6. Following up with Members to assess whether the Member has received needed services and if the Member is on track to reach their desired health outcomes.

6.4.3.2. Client/Family Centered characteristics include:

6.4.3.2.1. Ensuring that Members, and their families if applicable, are active participants in the Member's care, to the extent that they are able and willing.

6.4.3.2.2. Providing care and care coordination activities that are linguistically appropriate to the Member and are consistent with the Member's cultural beliefs and values

6.4.3.2.2.1. The Contractor shall provide cultural competency training to all of its new clinical staff members within three months of that staff member's hiring. The Contractor shall provide updated training to all staff members on an annual basis or as needed to address issues that arise in relation to cultural competency as requested by the Department.

6.4.3.2.3. Providing care coordination that is responsive to the needs of special populations, including, but not limited to:

6.4.3.2.3.1. The physically or developmentally disabled.

6.4.3.2.3.2. Children and foster children.

6.4.3.2.3.3. Adults and the aged.

6.4.3.2.3.4. Non-English speakers.

6.4.3.2.3.5. All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act.

6.4.3.2.3.6. Members in need of assistance with medical transitions.

6.4.3.2.3.7. Members with complex behavioral or physical health needs.

6.4.3.2.3.8. Members with HIV: In order to serve this population, the Contractor shall coordinate with the STD/HIV section of the Colorado Department of Public Health and Environment, which administers the Ryan White-funded program.

6.4.3.2.4. Providing care coordination that aims to keep Members out of a medical facility or institutional setting and provide care in the Member's community or home to the greatest extent possible. The Contractor shall ensure that all care coordination activities comply with the Supreme Court decision in Olmstead v. L. C. (527 U.S. 581 (1999)).

6.4.3.3. Integrated Care Coordination characteristics include:

6.4.3.3.1. Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care.

6.4.3.3.2. Providing services that are not duplicative of other services and that are mutually reinforcing.

6.4.3.3.3. Implementing strategies to integrate member care such as:

6.4.3.3.3.1. Developing a knowledge base of care providers, case management agencies and available services, both within the Contractor's network and the Members' communities.

6.4.3.3.3.2. Becoming familiar with the Department's initiatives and programs.

6.4.3.3.3.3. Knowing the eligibility criteria and contact points for community-based service available to the Member's in the Contractor's Region, subject to the Department's direction.

6.4.3.3.3.4. Identifying and addressing barriers to health in the in the Contractor's region, such as member transportation issues or medication management challenges.

6.4.4. The Contractor shall document its formal system of care coordination and deliver this documentation to the Department within sixty (60) days of the Contract's Effective Date.

6.4.4.1. DELIVERABLE: Documented formal system of care coordination.

6.4.4.2. DUE: Sixty (60) days from the Contract's Effective Date.

6.4.5. The Contractor shall provide the Department with an updated documentation of its formal system of care coordination whenever it makes any significant change to its system, when a series of minor changes have combined into a significant change from the prior system or upon the Department's request. The Contractor shall deliver this documentation to the Department within sixty (60) days of the change has occurred or from any request by the Department for updated documentation.

6.4.5.1. DELIVERABLE: Updated documentation of formal system of care coordination.

6.4.5.2. DUE: Sixty (60) days from the change or from the Department's request.

6.4.6. The Department may review the Contractor's formal system of care coordination at any time. The Department may direct changes in the Contractor's system of care coordination in the event that it determines any aspect of the system to be insufficient, inappropriate or otherwise unacceptable, for any reason. The Contractor shall immediately implement any changes directed by the Department and update its documentation of its formal system of care coordination accordingly.

6.4.7. The Contractor shall provide, and document in its formal system of care coordination, all of the following:

6.4.7.1. Individuals to act as emergency department diversion outreach specialists, located in local hospitals, to assist Members who present at the emergency department in explaining the medical home concept and scheduling follow-up appointments with their PCMP.

6.4.7.2. Individuals to act as patient navigators to address the medical, social and socio-economic needs of the Members in the Contractor's Region.

6.4.7.2.1. The patient navigators shall provide education to Members regarding available services that include, but are not limited to, public assistance, housing, nutrition and child care. This education shall also include the offer of additional supports for possibly unrecognized needs and assistance in accessing any additional services.

6.4.7.3. Individuals to act as service coordinators for Members, the Member's PCMP and other providers and the Member's family. These service coordinators shall interact with their assigned Members and providers, over the telephone, to provide information about Contractor and its provider network, provide Member assistance with PCMP selection, provide timely Member access to non-PCMP services and community resources, collect and enter additional data not contained in Medicaid claims data, and support all providers.

6.4.7.4. The Contractor shall ensure coordination between behavioral health and physical health providers.

6.4.7.5. A care team for each Member to assist the Member in access to care issues and in navigating systems, such as, medical, referral, public assistance, social services and patient accounts. This care team shall consist of, at a minimum, all of the following:

6.4.7.5.1. The Member's PCMP.

6.4.7.5.2. A behavioral health provider, if needed.

6.4.7.5.3. A dental provider, if needed.

6.4.7.5.4. Case management staff.

6.4.7.5.5. A referral specialist.

6.4.7.5.6. An emergency department diversion specialist.

6.4.7.5.7. A patient navigator.

SECTION 7.0 ACCOUNTABILITY

7.1. INITIAL PHASE PERFORMANCE METRICS

7.1.1. The Department shall calculate the regional baseline costs and utilization measures and make the baseline costs, calculation methodologies and utilization measures available to the Contractor in a reasonable timeframe. The Department shall calculate future cost and utilization measures using the same methodology as the baseline costs and utilization measures, and shall use these future costs and utilization costs to measure the Contractor's performance.

7.1.2. The Department shall only authorize the Contractor to enter the Expansion Phase if the future cost measurements show an aggregate reduction in costs for the Contractor's Region that meets the Department's budget goals. The Department shall determine whether any cost reduction meets the Department's budget goals in its sole discretion. The Department shall make reasonable efforts to provide the Contractor with cost reduction objectives so that the Contractor and its partners can align their efforts with the Department's program goals.

7.1.3. The Department shall measure the Contractor on the metrics contained in the Performance Target Table, as described in the following section on Expansion Phase Performance Metrics, during the Initial Phase. The Department shall make these measurements in order to create appropriate baselines and evaluate the Contractor's performance during the Initial Phase. The Department shall not pay the Contractor any incentive or other payment for meeting or exceeding any performance target before July 1, 2012.

7.1.3.1. The performance targets used to measure performance during the Initial Phase shall be the same as those used during the first year of the Expansion Phase.

7.1.3.2. The Department shall provide the Contractor monthly data on each performance target during the incentive payment pilot program. The data used by the Department to calculate the estimated incentive payment the Contractor would receive if the program was operational shall be based on the most recent ninety (90) day period for which complete data is available.

7.2. EXPANSION PHASE PERFORMANCE METRICS

7.2.1. Once the Contractor has entered the Expansion Phase, the Department shall begin enrolling additional members into the Contractor's plan at the Department's discretion. The Department may enroll any eligible Client within the Contractor's Region into the Contractor's plan, and the Contractor shall accept all new members enrolled by the Department.

7.2.2. The Department will use three performance targets to measure the Contractor during the first year of the Expansion Phase. The three performance targets will be Emergency Room Visits per 1,000 Full Time Enrollees (FTEs), Hospital Readmissions per 1,000 FTEs, and Outpatient Service Utilization of MRIs and CT Scans per 1,000 FTEs. The Department will use four performance targets to measure the Contractor during the second year of the Expansion Phase. The performance targets will be the three existing targets and Well Child Visits as defined by CMS 416 standards. The performance target goals will be the same as those described in the Section 9.2, Incentive Payments. The baseline for all performance targets listed in the following table shall be calculated based on the most recently available twelve (12) month period by the Department utilizing methodology that is fully disclosed to the Contractor in advance, with opportunity for consideration of comments submitted by the Contractor prior to finalization of the methodology by the Department.

7.2.3. The Department shall not include the AwDC population in the incentive payment calculations for the first year of their enrollment in the program. The incentive payments for this population shall be paid out based on the Contractor's performance for all other Full Time Enrollees.

7.2.4. During the second year of the Expansion phase and every subsequent year, the Department shall consult with the Contractor to determine the measurement areas and performance targets for the Contractor based on the Department's priorities, goals, objectives and initiatives. The Department shall amend this Contract to establish the new measurement areas and performance targets no later than March 1st.

7.2.5. The Department may institute a shared savings program during the expansion phase at its discretion. In the event that the Department decides to institute a shared savings program, it shall work with the Contractor to amend this Contract as necessary to institute the program.

7.3. PERFORMANCE IMPROVEMENT

7.3.1. The Contractor shall submit, for Department approval, a three (3) year performance improvement program that shall include an annual Performance Improvement Plan (PIP) update. The PIP shall describe:

7.3.1.1. The Contractor's health and health care performance improvement goals and objectives, based on national standards, the Department's priorities, goals, objectives and initiatives and the needs of the Contractor's Region.

7.3.1.2. The methods and strategies the Contractor will employ to achieve these stated goals and objectives.

7.3.1.3. A statement of a minimum of two (2) targeted performance improvement activities, the rational for choosing each activity and a plan for addressing them.

7.3.2. The Contractor shall deliver the PIP updates to the Department on an annual basis by October first of that year.

7.3.2.1. DELIVERABLE: Initial Performance Improvement Plan; Annual PIP update.

7.3.2.2. DUE: The Initial Performance Plan is due by October 1, 2011; the PIP Update is due annually, by October 1st of the year.

7.3.3. The Contractor shall include all relevant and available data, including those provided by the Department, the SDAC, claims data, prior authorization systems, registry data and data available through national collection initiatives, in any analysis, goal setting or the formulation of any strategy or plan.

7.3.4. The Department may review the Contractor's PIP at any time. The Department may direct reasonable changes in the Contractor's PIP in the event that it determines any aspect of the plan to be insufficient, inappropriate or otherwise unacceptable, for any reason. The Contractor shall immediately implement any reasonable changes directed by the Department and update its PIP accordingly.

7.4. FEEDBACK AND INNOVATION

7.4.1. The Contractor shall create a Performance Improvement Advisory Committee to provide input into the Contractor's implementation of the ACC Program and the Contractor's own performance improvement program. The Performance Improvement Advisory Committee shall:

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

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

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

7.4.1.3.1. Members.

7.4.1.3.2. Member's families.

7.4.1.3.3. Advocacy groups and organizations.

7.4.1.3.4. The PCMP network.

7.4.1.3.5. Other Medicaid providers.

7.4.1.3.6. The Behavioral Health community.

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

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

7.4.1.5. Open all scheduled meetings to the public.

7.4.1.6. Post the minutes of each meeting on the Contractor's website within ten (10) days of each meeting.

7.4.1.6.1. DELIVERABLE: Posted meeting minutes, meeting information for upcoming meetings, and the name and direct phone number of a contact person on the Contractor's website.

7.4.1.6.2. DUE: Ten (10) business days from the date of the meeting.

7.4.2. The ACC Program Improvement Advisory Committee

7.4.2.1. The Contractor shall provide one person to serve as a member of the Department's ACC Program Improvement Advisory Committee. This individual shall be the Contractor's representative to the ACC Program Improvement Advisory Committee.

7.4.3. SDAC Operations Committee

7.4.3.1. The Contractor shall provide one person to serve as a member of the Department's SDAC Operations Committee. This individual shall be the Contractor's representative to the SDAC Operations Committee.

7.4.4. AwDC expansion workgroup.

7.4.4.1. The Contractor shall provide one staff person to serve as a member of the AwDC expansion workgroup.

7.4.5. The Contractor's representative on each of the committees described in this section may serve on any number of committees, as time permits. If conflicting meetings, other obligations or any other event does not permit the Contractor's representative from attending a meeting, the Contractor shall provide an alternate representative to attend the meeting that the regular representative could not attend. The Contractor's representative shall attend all meetings in person, unless granted prior approval to attend through telephone, video conference or other means by the Department.

7.4.6. The Department may request the Contractor provide an replacement representative, for any of the committees in this section, from the Contractor in the event that the Department determines, in its sole discretion, that the existing representative is unacceptable or if the representative shows a pattern of being disruptive during meetings, being tardy to regularly scheduled meetings or failing to attend regularly scheduled meetings. In the event that the Department requests a replacement representative, the Contractor shall provide the replacement representative by the next regularly scheduled meeting of that committee.

SECTION 8.0 PROGRAM REPORTING

8.1. ADMINISTRATIVE REPORTING

8.1.1. Network Report

8.1.1.1. The Network Report shall contain:

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

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

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

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

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

8.1.1.3.1. DELIVERABLE: Network Report.

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

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

8.1.1.4.1. DELIVERABLE: Interim Network Report.

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

8.1.2. Program Integrity Report

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

8.1.2.2. The Contractor shall report any suspicion or knowledge of fraud or abuse to the Department immediately upon receipt of the information causing suspicion or knowledge of the fraud or abuse.

8.1.2.3. The Contractor shall prepare a written program integrity report detailing the specific background information of any reported fraud or abuse, the name of the provider and a description of how the Contractor became aware of the information that led to the report. The Contractor shall deliver this Program Integrity Report to the Department within ten (10) business days from when it reported the fraud or abuse to the Department.

8.1.2.3.1. DELIVERABLE: Program Integrity Report.

8.1.2.3.2. DUE: Ten (10) days from the initial report of the fraud or abuse.

8.1.2.4. The Contractor shall report any possible instances of a Member's fraud, such as document falsification, to the department of human or social services in the county in which the Member resides, immediately upon gaining information leading to knowledge of the fraud or suspicion of fraud. The Contractor shall deliver a written report of the possible instances of the Member's fraud detailing the specific background information of the reported fraud, the name of the Member and a description of how the Contractor became aware of the information that led to the report. The Contractor shall deliver this Member fraud report to the county department to which it made its initial report within ten (10) business days from when it reported the fraud to the county department.

8.1.2.4.1. DELIVERABLE: Member Fraud Report.

8.1.2.4.2. DUE: Ten (10) days from the initial report of the fraud or abuse.

8.2. PERFORMANCE REPORTS

8.2.1. Performance Measures and Activities Report

8.2.1.1. The Contractor shall draw the appropriate data, information and reports from the SDAC to create its Performance Measures and Activity Report. The Performance Measures and Activity Report shall contain:

8.2.1.1.1. The Contractor's performance for the most recently completed calendar quarter in relation to the performance metrics described in Section 7.0 of this Statement of Work, the Contractor's current PIP activities and any metrics, goals or objectives given to the Contractor by the Department.

8.2.1.1.2. The Contractor's performance on all applicable metrics, goals and objectives from the previous four (4) quarters.

8.2.1.1.3. The Contractor's cumulative performance on all metrics, goals and objectives over the past twelve (12) consecutive months.

8.2.1.1.4. A summary of the Contractor's performance improvement activities completed during the previous quarter, currently in progress and planned for the upcoming quarter.

8.2.1.2. The Contractor shall provide the Performance Measures and Activity Report, to the Department, on a quarterly basis, within thirty (30) days from the end of the quarter that the report covers.

8.2.1.2.1. DELIVERABLE: Performance Measures and Activity Report.

8.2.1.2.2. DUE: Thirty (30) days from the end of the quarter that the report covers.

8.2.1.3. The Department shall make available to the Contractor all data in the MMIS, including, but not limited to, behavioral health encounters, physical health claims, dental claims and pharmacy claims on a monthly basis to support the generation of the reports described in this section.

8.2.2. Integration Reporting

8.2.2.1. The Contractor shall submit to the Department a report that includes an environmental scan of current practices, challenges, and new strategies for integration of behavioral and physical health care for all covered populations. The Contractor shall collaborate with the BHOs in its region to create the report.

8.2.2.1.1. DELIVERABLE: Behavioral Health Integration Report.

8.2.2.1.2. DUE: July 1, 2012.

8.2.3. Integrated care

8.2.3.1. The Contractor shall submit a semi-annual report describing all of the following:

8.2.3.1.1. Integrated care efforts and continuing challenges.

8.2.3.1.2. Updates on strategies identified in the Behavioral Health Integration Report

8.2.3.1.3. DELIVERABLE: Integrated Care Report.

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

8.2.4. Member Outreach and Stakeholder Feedback Report

8.2.4.1. The Member Outreach and Stakeholder Feedback Report shall contain:

8.2.4.1.1. A summary of the feedback received from Members and other stakeholders, through any advisory committee or through any other means.

8.2.4.1.2. A description of trends and themes in the feedback received.

8.2.4.1.3. A description of overarching issues to address or system-wide problems that must be solved and a proposal to address these issues or solve the problems.

8.2.4.1.4. A summary of the feedback and complaints from Members, providers and the community at large and any advice or views expressed by the Contractor's Performance Improvement Advisory Committee.

8.2.4.1.5. Challenges identified in serving the AwDC population.

8.2.4.1.6. Lessons learned from the AwDC population related to their health needs and behaviors.

8.2.4.1.7. The results of the prior quarter's attempts to contact Members as described in section 3.1.1.3.2, including the success rate of connecting Members without a PCMP to a PCMP.

8.2.4.1.8. The Contractor's plan for contacting Members without a PCMP during the following quarter.

8.2.4.1.9. The results of the prior quarter's outreach to all Members, as described in section 3.2.7.

8.2.4.2. The Contractor shall provide the Stakeholder Feedback Report, to the Department, on a quarterly basis, within thirty (30) days from the end of the quarter that the report covers.

8.2.4.3. The Member Outreach and Stakeholder feedback report may contain information that is not reflected in the Contractor's regular grievance process and the information contained in such a report is not indicative of a weakness or limitation of the Contractor or the Contractor's systems.

8.2.4.3.1. DELIVERABLE: Member Outreach and Stakeholder Feedback Report.

8.2.4.3.2. DUE: Thirty (30) days from the end of the quarter that the report covers.

8.3. REPORT VERIFICATION

8.3.1. The Department may, in its sole discretion, verify any information the Contractor reports to the Department for any reason. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

8.3.1.1. Fact-checking.

8.3.1.2. Auditing reported data.

8.3.1.3. Requesting additional information.

8.3.1.4. Performing site visits.

8.3.2. In the event that the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated report, which corrects all errors and includes all omitted data or information, and submit the updated report to the Department within ten (10) days from the Department's request for the updated report.

8.3.2.1. DELIVERABLE: Updated reports.

8.3.2.2. DUE: Ten (10) days from the Department's request for an updated or corrected report.

8.4. REPORT FORMAT OR TEMPLATES

8.4.1. The Contractor shall provide all reports in a format or template directed by the Department. The Department will develop the templates with input from the Contractor. The Contractor shall ensure that all reports comply with the specific guidance provided by the Department related to that report.

SECTION 9.0 COMPENSATION

9.1. PMPM PAYMENTS

9.1.1. The Department shall pay the Contractor, through the Colorado MMIS, a monthly PMPM Payment for each active Member enrolled in the Contractor's plan on the first day of that month at the following rates:

Description	Period	PMPM Amount
A. All Members	Effective Date through June 30, 2012	$13.00
B. All Members	July 1, 2012 through October 31, 2012	$12.00
C. All Members	November 1, 2012 forward	$9.50
D. Additional for Members eligible for Medicaid through the AwDC.	Effective Date forward	$3.00

9.1.1.1. The PMPM payments shall only be made during the Initial Phase and the Expansion Phase. The Contractor shall not receive any PMPM Payment before the beginning of the Initial Phase.

9.1.1.2. The number of active Members enrolled in the Contractor's plan shall be calculated based on the number of enrollments in the Colorado Medicaid Management Information System.

9.1.1.3. The Department shall remit all PMPM Payments to the Contractor within the month for which the PMPM Payment applies. In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, the Department shall compensate the Contractor for that Member.

9.2. INCENTIVE PAYMENT

9.2.1. After July 1, 2012 and when the Contractor has been moved into the Expansion Phase, the Department shall pay the Contractor an Incentive Payment, through the MMIS, when the Contractor meets or exceeds the Level 1 Targets or Level 2 Targets, as calculated based on region-wide performance and described in Section 7.2 of this Statement of Work. In the event that the Contractor meets or exceeds the Level 2 target for any Measurement Area, the Contractor shall only receive the Level 2 Target Incentive Payment in place of the Level 1 Target Incentive Payment.

9.2.2. The following table describes the amounts available for each measurement area and the amount the Contractor may receive if it meets the stated performance targets.

9.2.2.1. Incentive Payment Table

Measurement Area	Performance Target Percentage Improvement	Total Incentive Payment
A. Emergency Room Visits per 1,000 Full Time Enrollees (FTEs)	Level 1 Target: Total Emergency Room Visits reduced at least 1.0% and less than 5.0% below baseline Level 2 Target: Total Emergency Room Visits reduced between 5.0% or more below baseline	Level 1 Target: 66% of the Full Amount Level 2 Target: 100% of the Full Amount Full Amount: Adults $0.30 PMPM Children (0-20) $0.20 PMPM

B. Hospital Re-admissions per 1,000 FTEs	Level 1 Target: Total Hospital Re-admissions reduced at least 1.0% and less than 5.0% below baseline Level 2 Target: Total Hospital Re-admissions reduced between 5.0% or more below baseline	Level 1 Target: 66% of the Full Amount Level 2 Target: 100% of the Full Amount Full Amount: Adults $0.30 PMPM Children (0-20) $0.20 PMPM
C. Outpatient Service Utilization of MRIs and CT scans per 1,000 FTEs	Level 1 Target: Total Outpatient Service Utilization of MRIs and CT scans reduced at least 1.0% and less than 5.0% below baseline Level 2 Target: Total Outpatient Service Utilization of MRIs and CT scans reduced between 5.0% or more below baseline	Level 1 Target: 66% of the Full Amount Level 2 Target: 100% of the Full Amount Full Amount: Adults $0.30 PMPM Children (0-20) $0.20 PMPM
D. Well Child Visits (CMS 416) per 1,000 FTEs	Level 1 Target: Increase in well child visits of at least 1.0% and less than 5.0% above baseline. Level 2 Target: Increase in well child visits of 5.0% or more above baseline.	Level 1 Target: 66% of the Full Amount Level 2 Target: 100% of the Full Amount Full Amount: Adults $0.10 PMPM Children (0-20) $0.40 PMPM

9.2.2.2. The Department shall remit all Incentive Payments to the Contractor on a quarterly basis within one-hundred and eighty (180) days from the last day of the quarter in which the Incentive Payments were earned. The Department will calculate the Incentive Payment separately for each month in a quarter, and the Contractor may receive different amounts for each month within a quarter based on the specific performance targets the Contractor was able to meet during each specific month.

9.3. PAYMENT CALCULATION DISPUTES

9.3.1. In the event that the Contractor believes that the calculation or determination of any Incentive Payment or PMPM is incorrect, the Contractor shall notify the Department of its dispute within thirty (30) days of the receipt of the payment. The Department shall review calculation or determination and may make changes based on this review. The determination or calculation that results from the Department's review shall be final. No disputed payment shall be due until after the Department has concluded its review.

SECTION 10.0 STARTUP PROCESS

10.1. START-UP PHASE

10.1.1. During the Start-Up Phase, the Contractor shall:

10.1.1.1. Establish an Implementation Plan that includes a schedule of activities and milestones for the Start-Up Phase and the Initial Phase within seven (7) days from the Contract's Effective Date.

10.1.1.1.1. DELIVERABLE: Implementation Plan.

10.1.1.1.2. DUE: Seven (7) days from the Contract's Effective date.

10.1.1.2. Create a Start-Up Plan containing the following components:

10.1.1.2.1. The Organizational Chart described in section 2.2.7 of this Statement of Work.

10.1.1.2.2. A Customer Service Plan that describes how the Contractor will track incoming telephone calls, emails and other contact from providers, Members and the general public, how it plans to fulfill its customer service requirements and similar customer service related items.

10.1.1.2.3. A timeline for the creation of the website for the Contractor's Region and a description of the contents and structure of the site or a prototype of the website.

10.1.1.2.4. The ACC Program Member Handbook section specific to the Contractor's Region as described in Section 3.2.3.1 of this Statement of Work.

10.1.1.2.5. A description of how the Contractor intends to provide necessary provider orientation to the ACC Program and the Contractor's network and a plan for providing necessary provider training.

10.1.1.2.5.1. DELIVERABLE: Start-Up Plan.

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

10.1.1.3. Cooperate with the Department in the Department's Operational Readiness Review, including, but not limited to:

10.1.1.3.1. Providing all information, data or reports the Department requires or requests that are within the scope of the Operational Readiness Review.

10.1.1.3.2. Allowing the Department reasonable access to the Contractor's facilities and staff.

10.1.1.3.3. Developing and implementing any corrective action plan, as directed by the Department.

10.1.1.4. Complete all other deliverables contained in this Contract with a due date that occurs in the Start-Up Phase, including, but not limited to, all of the following:

10.1.1.4.1. The Communication Plan.

10.1.2. During the Start-Up Phase, the Department shall:

10.1.2.1. Work with the Contractor to define project management and reporting standards.

10.1.2.2. Work with the Contractor to define expectations for content and format of all deliverables in the Contract.

10.1.2.3. Initiate an Operational Readiness Review to determine the Contractor's readiness and ability to provide services to its Members and resolve any identified operational deficiencies. The Department may require the Contractor to develop and implement a corrective action plan to remedy any deficiencies found during the Operational Readiness Review.

SECTION 11.0 TRANSITION AT TERMINATION

11.1. CONTRACTOR'S TRANSITION REQUIREMENTS

11.1.1. Upon termination of the Contract for any reason, the Contractor shall do all of the following for a period not to exceed sixty (60) days before termination of the Contract:

11.1.1.1. Provide the Department with all information related to the Contractor's PCMP Network, its Members and the services provided to those Members, for transition to the Department or any other contractor of the Contractor's responsibilities.

11.1.1.2. Provide for the uninterrupted continuation of all network management, care coordination and administrative services until the transition of every Member is complete and all requirements of the Contract are satisfied.

11.1.1.3. Designate an appropriate individual as the transition coordinator to work with the Department and any staff from the replacement contractor to ensure the transition does not adversely impact any member's care.

11.1.1.4. Provide to the Department all reports reasonably necessary for a transition.

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

11.1.1.6. Notify all of the Members in the Contractor's Region that the Contractor will no longer be the RCCO for the region, in a form and manner approved by the Department.

11.1.1.7. Notify each PCMP in the Contractor's PCMP Network of the termination and the end date of the Contract and explain to the provider how the provider may continue participating in the ACC Program.

11.1.1.8. Cooperate with the Department and any other replacement contractor during the transition, including, but not limited to, using reasonable efforts to share and transfer Member information and following any instructions or performing any required actions, as reasonably directed by the Department.

11.1.1.9. Provide the Department, in a format prescribed and approved by the Department:

11.1.1.9.1. A list of all PCMPs in the Contractor's PCMP Network.

11.1.1.9.2. A list of all Members in the Contractor's Region.

SECTION 12.0 GENERAL REQUIREMENTS

12.1. CONTRACTORS AND SUBCONTRACTORS

12.1.1. Department Contractors

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

12.1.2. Subcontractors

12.1.2.1. Other than the care coordination provided by any PCMP, the Contractor shall not subcontract more than forty percent (40%) of its responsibilities under the Contract, based on the total annual Contract value, to any other entity and it shall not subcontract more than

twenty percent (20%) of its responsibilities under the Contract, based on the total annual Contract value, to any single entity.

12.1.2.2. The Contractor shall not enter into any agreement with a Subcontractor or have any Subcontractor begin work in relation to the Contract until it has received the express, written consent of the Department to subcontract with the specific Subcontractor. This consent requirement shall only apply to subcontracts that relate to ten percent (10%) or more of the responsibilities under the Contract, based on the total annual Contract value.

12.1.2.3. Any agreement the Contractor has with a Subcontractor shall be in writing and shall require compliance with all of the terms in this Contract.

12.2. NO MEDICAL TREATMENT DIRECTION

12.2.1. The Contractor may make recommendations and provide support to PCMPs and their Members to improve health outcomes, but shall not, under any circumstance, direct treatment or require the PCMP or Member to make any decision regarding that Member's health care.

12.2.2. The Contractor may not create or make any referrals, on behalf of any Member or provider, in its role as a RCCO. Only a provider may create or make any referrals, and the Contractor may facilitate the referral process and provide support for providers when the provider creates or makes a referral.

12.3. DUE DATE AND TIMELINES

12.3.1. All due dates, deadlines and timelines in this Statement of Work are measured in calendar days unless specifically stated otherwise. Additionally, all due dates, deadlines and timelines in this Contract, based on quarters, refer to state fiscal year calendar quarters, with the first quarter beginning on July 1st of each year. In the event that any due date or deadline falls on a weekend, a Department holiday or other day the Department is closed, the due date or deadline shall be automatically extended to the next business day the Department is open.

12.3.2. The Department may, in its sole discretion, extend the due date, deadline or timeline of any activity, deliverable or requirement under this Statement of Work. Any such extension shall only be valid if it is delivered to the Contractor in writing, in either a hard copy or electronic format.

12.3.3. All Contract deliverables shall be submitted electronically to acc@state.co.us and the Department's contract manager.

12.4. CYBER SECURITY

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

12.5. DISPUTES BETWEEN RCCOS

12.5.1. The Contractor shall cooperate with any other RCCO to resolve any dispute, regarding the ACC Program's policies, between the Contractor and the RCCO relating to any ACC Program related issue, including, but not limited to, issues relating to providers within the ACC Program, Members, performance target measurements or PMPM Payments. If the Contractor and another RCCO are unable to reach a resolution to the dispute, the Contractor shall submit a notice of the dispute to the Department. The Department may conduct any investigation or

hearing it deems appropriate to the dispute, and shall make a final determination on the dispute. The Contractor shall abide by the Department's decision relating to any dispute described in this section.

12.6. DEBARRED ENTITIES

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

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

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

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

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

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

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

12.7. FEDERAL INTERMEDIATE SANCTIONS

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

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

12.7.2.1. The basis and nature of the sanction.

12.8. TERMINATION UNDER FEDERAL REGULATIONS

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

12.8.1.1. Carry out the substantive terms of its contracts.

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

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

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

12.8.2.1.1. The Department's intent to terminate.

12.8.2.1.2. The reason for the termination.

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

12.8.2.2. Conduct a pre-termination hearing.

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

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

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

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

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

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

12.9. INFORMATION AVAILABILITY

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

12.10. RETROSPECTIVE ENROLLMENT AND DISENROLLMENT

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

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

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

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

12.11. FEDERAL DISCLOSURES OF INFORMATION ON OWNERSHIP AND CONTROL

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

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

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

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

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

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

12.11.1.4. The name of any other entity required to disclose under 42 CFR 455.104 in which any owner of the Contractor has an ownership or control interest.

12.11.1.5. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.

12.11.2. "Ownership interest" and "person with an ownership or control interest" shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended. "Subcontractor", for purposes of this subsection 3.1.8 only, shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended.

12.11.3. The Contractor shall complete these disclosures upon execution of the Contract. The Contractor shall deliver new disclosures to the Department within thirty-five (35) days of the any change in ownership of the Contractor.

12.12. SDAC ACCESS COMPLIANCE

12.12.1. The Contractor shall comply with the Department's SDAC Web Portal access policy.

EXHIBIT E
DELIVERABLES

DUE DATE AND TIMELINES

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

CONTRACT DELIVERABLES

2.2.9.1 DELIVERABLE: **Updated Organizational Chart.**

2.2.9.2 DUE: Five (5) days from any change in Key Personnel of from the Department's request for an updated Organizational Chart.

3.2.1.3.1 DELIVERABLE: **Updated client materials** including changes required by the Department.

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

3.2.3.1.3. DELIVERABLES: **ACC Program Member Handbook** – updated section specific to the Contractor's Region, when significant changes occur.

3.2.3.1.4. DUE: Thirty (30) days from the effective date of the changes.

3.2.3.2.1. DELIVERABLES: **PCMP Directory.**

3.2.3.2.2 DUE: by the Go-Live Date and monthly by the first day of the month, unless extension is allowed by the Department.

4.3.1.1 DELIVERABLE: **Provider and community resource relationship documentation.**

4.3.1.2 DUE: Semiannually by January 31st and July 31st.

4.3.2.3.1 DELIVERABLE: **Annual communication plan.**

4.3.2.3.2 DUE: Annually on July 1st and thirty (30) days from the date of any change for an

updated communication plan.

5.1.1.3.1 DELIVERABLE: All **provider support documents** and direct provider contact plans.

5.1.1.3.2 DUE: Ten (10) days from the date the documents or plans are requested by the Department; and ten (10) days from the request by the Department to make a change for updated documents.

5.2.1.3.1 DELIVERABLE: **Practice Support Plan**.

5.2.1.3.2 DUE: Annually, within the first three (3) months of the state fiscal year.

6.1.1.1.1 DELIVERABLE: **Clinical Referral Protocol**.

6.1.1.1.2 DUE: No later than June 30, 2013.

6.1.1.2.1 DELIVERABLE: **Updated Clinical Referral** Protocol including all changes directed by the Department.

6.1.1.2.2 DUE: Within three (3) Business Days from the Department's request for a change, unless more time is granted by the Department.

6.4.5.1 DELIVERABLE: **Updated documentation of formal system of care coordination**.

6.4.5.2 DUE: Sixty (60) days from the change or from the Department's request.

7.3.2.1 DELIVERABLE: **Initial Performance Improvement Plan; Annual PIP update**.

7.3.2.2 DUE: The Initial Performance Plan is due by October 1, 2011; the PIP Update is due annually, by October 1st of the year.

7.4.1.6.1. DELIVERABLE: **Posted meeting minutes**, meeting information for upcoming meetings, and the name and direct phone number of a contact person on the Contractor's website.

7.4.1.6.2. DUE: Ten (10) business days from the date of the meeting.

8.1.1.3.1 DELIVERABLE: **Network Report.**

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

8.1.1.4.1	DELIVERABLE: **Interim Network Report.**
8.1.1.4.2	DUE: within ten (10) Business Days after the Department's request for the interim Network Report.
8.1.2.3.1	DELIVERABLE: **Program Integrity Report.**
8.1.2.3.2	DUE: Ten (10) days from the initial report of the fraud or abuse.
8.1.2.4.1	DELIVERABLE: **Member Fraud Report.**
8.1.2.4.2	DUE: Ten (10) days from the initial report of the fraud or abuse.
8.2.1.2.1	DELIVERABLE: **Performance Measures and Activity Report. (currently on hold)**
8.2.1.2.2	DUE: Thirty (30) days from the end of the quarter that the report covers.
8.2.3.1.3	DELIVERABLE: **Integrated Care Report**.
8.2.3.1.4	DUE: Semi-annually, by January 31st and July 31st of each year.
8.2.4.3.1	DELIVERABLE: **Member Outreach and Stakeholder Feedback Report**.
8.2.4.3.2	DUE: Thirty (30) days from the end of the quarter that the report covers.