CONTRACT AMENDMENT NO. 6

Original Contract Number 15-68386

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Foothills Behavorial Health Partners, LLC, 9101 Harlan Street, #100, Westminster, CO 80031, (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 administer the Community Behavioral Health Services Program (the Program) that provides comprehensive mental health and substance use disorder services to Medicaid clients in Colorado. The purpose of this Amendment is to extend the term of the contract and update Exhibits A, B, D, G, I and J.

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 5, Term, Subsection A, Initial Term, is hereby deleted in its entirety and replaced with the following:

A. Initial Term

The Parties' respective performances under this Contract shall commence on the later of either the Effective Date or July 1, 2014. This Contract shall expire on

June 30, 2017, unless sooner terminated or further extended as specified elsewhere herein.

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

C. Exhibit B-4, Rates, is hereby deleted in its entirety and replaced with Exhibit B-5, Rates, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit B, B-1, B-2, B-3 or B-4, shall be deemed to reference to Exhibit B-5.

D. Exhibit D-1, Covered Behavioral Health Diagnoses, is hereby deleted in its entirety and replaced with Exhibit D-2, Covered Behavioral Health Diagnoses, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit D or D-1, shall be deemed to reference to Exhibit D-2.

E. Exhibit G, Performance Measures, is hereby deleted in its entirety and replaced with Exhibit G-1, Performance Measures, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit G, shall be deemed to reference G-1.

F. Exhibit I, Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI), is hereby deleted in its entirety and replaced with Exhibit I-1, Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI), attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit I, shall be deemed to reference Exhibit I-1.

G. Exhibit J, Developmental Disability, is hereby deleted in its entirety and replaced with Exhibit J-1, Developmental Disability, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit J, shall be deemed to reference to Exhibit J-1.

7. START DATE

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

8. ORDER OF PRECEDENCE

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

9. AVAILABLE FUNDS

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

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THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

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

CONTRACTOR:
Foothills Behavorial Health Partners, LLC

By: _____
Signature of Authorized Officer

Date: _____

_____
Printed Name of Authorized Officer

_____
Printed Title of Authorized Officer

STATE OF COLORADO:

John W. Hickenlooper, Governor

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

Date: _____

LEGAL REVIEW:
Cynthia H. Coffman, Attorney General

By: _____

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: _____

EXHIBIT A-2, STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY

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

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

1.1.1.2. Action – Denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner, as a defined by the State; or the failure of the Contractor to process grievances, appeals or expedited appeals within required timeframes.

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

1.1.1.4. All-Payer Claims Database (APCD) – statewide information repository that collects health insurance claims information from all healthcare payers.

1.1.1.5. Appeal – Request for review of an action.

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

1.1.1.7. Behavioral Health Organization (BHO) – The managed care entity contracting with the Department to provide behavioral health services to Medicaid eligible individuals on a risk contracting basis.

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

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

1.1.1.10. CFR – The Code of Federal Regulations.

1.1.1.11. CHP+ – The Colorado Child Health Plan *Plus*.

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

1.1.1.13. Community Behavioral Health Services Program (Program) – A statewide program that provides comprehensive mental health and substance use disorder services to eligible Colorado Medicaid members.

1.1.1.14. Community Centered Boards (CCB) – means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5-105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. et seq, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

1.1.1.15. Client – Any individual enrolled in the Colorado Medicaid program as determined by the Department.

1.1.1.16. Contractor's Service Area – The geographical area served by the Contractor under the Contract. This Contractor's Service Area shall include the Metro East Region of Colorado as defined by the Department.

1.1.1.17. Designated Client Representative – any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services.

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

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

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

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

1.1.1.20.2. Serious impairment to bodily functions.

1.1.1.20.3. Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

1.1.1.27. Grievance – An expression of dissatisfaction about any matter other than an "action."

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

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

1.1.1.30. Integration of Care – Coordinated and unified treatment of health concerns across the physical and behavioral health spectrum.

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

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

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

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

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

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

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

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

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

1.1.1.36. Member – Any Medicaid eligible individual that is enrolled in the Community Behavioral Health Services Program.

1.1.1.37. Modified Adjusted Gross Income (MAGI) Adults –A category of Medical Assistance for adults who are at least age nineteen (19) but less than sixty-five (65) years without Medicaid eligible dependent children living in the member's household. SSI disability determination is not required for this population. This is the expansion group under federal definitions. This includes parents >68% to 133% FPL and Childless adults 0% to 133% FPL, ages 19-64. Medicare clients are excluded from this group..

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

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

1.1.1.40. Nursing Facility – An institution that meets state and federal requirements for participation as a Nursing Facility.

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

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

1.1.1.43. PHI – Protected Health Information.

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

1.1.1.45. Performance Incentive Program – An initiative aimed at improving the quality, efficiency, and overall value of Member care that provides financial incentives to BHOs that achieve optimal outcomes for members.

1.1.1.46. Physician – Any doctor contracted to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.

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

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

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

1.1.1.50. Primary Care Medical Provider (PCMP) – A primary care provider who serves as a Medical Home for Members. PCMP practices may be Federally Qualified Health Centers, RHCs, clinics or other group practices that provide the majority of a Member's comprehensive primary, preventive and sick care. Individual PCMPs can be physicians, advanced practice nurses, or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

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

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

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

1.1.1.54. Rural Health Center Encounter Rate – The rate established by the Department to reimburse Rural Health Centers.

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

1.1.1.56. Service Authorization – The request by a Member for a Medically Necessary Covered Service.

1.1.1.57. Single Entry Point (SEP) – The availability of a single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care programs and case management services.

1.1.1.58. Single Entry Point Agency (SEP Agency) – The organization selected to provide case management functions for persons in need of long-term care services within a District. Single Entry Point Agencies may function as a Utilization Review Contractor.

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

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

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

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

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

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

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

1.1.1.66. U.S.C. – The United States Code

1.1.1.67. Wrap Around Services – Those Medicaid services which either exceed coverage limitations the Contractor is required by this Contract to provide or, the Contractor is not obligated to provide coverage for under this Contract. Wrap Around Benefits are services reimbursable under the Medicaid fee-for-service and must be billed directly to the Department's fiscal agent by the Provider. Wrap Around Benefits include, but are not limited to, EPSDT Extraordinary Home Health Services, medical transportation, and private duty nursing.

1.1.1.68. Written Referral/Referral – Any form or written communication by the Contractor that authorizes specific behavioral health and/or Hospital Services. A Written Referral shall be utilized for Covered Service(s) to be performed by Referral Providers.

SECTION 2.0 ENROLLMENT, POPULATIONS SERVED AND COVERED SERVICES

2.1. ENROLLMENT

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

2.1.1.1. Enrollment into the Program occurs automatically each month and is effective on the day in which the individual becomes eligible for Medicaid. Members shall be automatically reenrolled if there is a loss of Medicaid eligibility of two (2) months or less.

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

2.1.1.3. The Contractor shall accept individuals eligible for enrollment in the order in which they are enrolled without restriction.

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

2.1.3. Disenrollment from the Program

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

2.1.3.2. A Member (or his/her representative) must submit a request for disenrollment to the Department.

2.1.3.2.1. If the Contractor receives a request for disenrollment, the Contractor shall refer the request to the Department for processing.

2.1.3.2.2. The Department shall, upon request for disenrollment, notify the Contractor and request Member information to aid the Department in rendering a decision.

2.1.3.3. The effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the Member files a request.

2.1.3.3.1. If the Department fails to make a disenrollment determination with the specified timeframe, the disenrollment is considered approved.

2.1.3.4. The Contractor shall not be permitted to request disenrollment of a member for any reason pursuant to a waiver of 42 CFR 438.56(b).

2.1.3.5. If the Member is dissatisfied with the Department's determination that there is not good cause for disenrollment, the Member may seek a State Fair Hearing in accordance with Section 2.6.7 of the Contract.

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

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

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

2.1.5.2. Qualified Disabled and Working Individuals (QDWI).

2.1.5.3. Qualified Individuals 1 (QI 1).

2.1.5.4. Special Low Income Medicare Beneficiaries (SLMB).

2.1.5.5. Undocumented aliens.

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

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

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

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

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

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

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

2.1.5.10. Individuals residing in the state regional centers and associated satellite residences for more than ninety (90) days; Classes of individuals determined by the Department to require exclusion from the Community Behavioral Health Services Program.

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

2.1.5.12. All individuals while determined presumptively eligible for Medicaid.

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

2.1.6. The Contractor shall not discriminate against Members eligible to enroll 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. The Contractor shall also not discriminate against Members eligible to enroll on the basis of health status or need for health care services.

2.1.7. The Contractor shall allow each Member to choose his or her health professional to the extent possible and appropriate.

2.2. COVERED SERVICES

2.2.1. The Contractor shall provide or arrange for the provision of all medically necessary Covered Services, diagnoses and procedures as indicated in Exhibit D of this contract, Uniform Service Coding Standards (USCS) Manual, including services identified under the federal Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), 42 CFR Sections 441.50 to 441.62.

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

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

2.2.3. Members shall not be liable for any Covered Services:

2.2.3.1. Provided to the member, for which the Department does not pay the Contractor;

2.2.3.2. Provided to the Member, for which the Department or Contractor does not pay the provider that furnishes the service under a contract, referral, or other arrangement; or

2.2.3.3. Furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the services directly.

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

2.2.4.1. Inpatient Psychiatric Hospital Services

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

2.2.4.1.1.1. The Contractor shall be financially responsible for the hospital stay when the Member's primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures (including labs and ancillary services).

2.2.4.1.1.2. The Contractor shall not be financially responsible for inpatient hospital services when the Member's primary diagnosis is physical in nature, even when the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis.

2.2.4.1.1.3. The Contractor shall not be financially responsible for inpatient hospital services when the Member's primary diagnosis is a substance use disorder that is evident at the time of admission.

2.2.4.1.1.4. The Contractor shall be financially responsible for a Member's admission to any free standing inpatient psychiatric facility, when the Member is presenting with psychiatric symptoms, for the purposes of acute stabilization, safety and assessment to determine whether or not the primary diagnosis occasioning the Member's admission to the hospital is a mental health disorder or substance use disorder.

2.2.4.1.1.4.1. The Contractor shall be financially responsible until a substance use disorder diagnosis is determined to be the primary diagnosis, at which point the Contractor shall no longer be responsible for continued acute stabilization, safety, and assessment services associated with that admission.

2.2.4.1.1.4.2. If a mental health disorder is determined to be the primary diagnosis, the Contractor shall be financially responsible for the remainder of the inpatient hospital services, as medically necessary. The assessment period shall generally not exceed seventy-two (72) hours.

2.2.4.2. Outpatient services, including:

2.2.4.2.1. Rehabilitative services.

2.2.4.2.1.1. Group psychotherapy.

2.2.4.2.1.2. Individual psychotherapy.

2.2.4.2.1.3. Family psychotherapy.

2.2.4.2.1.4. Behavioral health assessment.

2.2.4.2.1.5. Pharmacological management.

2.2.4.2.1.6. Outpatient day treatment.

2.2.4.3. Emergency/Crisis Services

2.2.4.3.1. Emergency services that are:

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

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

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

2.2.4.3.3. The Contractor shall be responsible for practitioner emergency room claims billed on a CMS 1500 for Members diagnosed with a primary substance use and/or mental health disorder.

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

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

2.2.4.3.4.1.1. The Contractor shall pay non-contracted providers for emergency services no more than the amount that would been paid if the service had been provided under the State's FFS Medicaid program.

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

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

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

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

2.2.4.3.5. The Contractor shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member.

2.2.4.3.6. The attending emergency Physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor for coverage and payment.

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

2.2.4.3.8. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's network that are not pre-approved by the Contractor, but that are administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

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

2.2.4.3.8.2. The Contractor cannot be contacted.

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

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

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

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

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

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

2.2.4.3.9.4. The Member is discharged.

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

2.2.4.3.11. The Contractor shall be financially responsible for Emergency Services when the Member's primary diagnosis is for a covered mental health disorder even when some physical health conditions are present or a medical procedure is provided.

2.2.4.3.12. The Contractor shall not be financially responsible for outpatient emergency room services billed on a UB-04 for Members with a primary substance use disorder diagnosis. The Contractor shall be responsible for practitioner emergency room claims billed on a CMS 1500 for Members with a primary substance use or mental health disorder diagnosis.

2.2.4.3.13. The Contractor shall not be financially responsible for Emergency Services when the primary diagnosis is medical in nature even when procedures are provided to treat a secondary behavioral health diagnosis.

2.2.4.4. School-based services.

2.2.4.5. Targeted case management.

2.2.4.6. Substance Use Disorder assessments.

2.2.4.7. Alcohol/drug Screen Counseling.

2.2.4.8. Medication Assisted Treatment.

2.2.4.9. Coverage for Outpatient Hospital Services.

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

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

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

2.2.4.9.1.1.2. The primary diagnosis is a covered psychiatric diagnosis.

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

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

2.2.4.9.1.2.2. The primary diagnosis is a covered behavioral health diagnosis.

2.2.4.10. Social Ambulatory Detox services including, but not limited to, the following:

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

2.2.4.10.2. Level of motivation assessment for treatment evaluation.

2.2.4.10.3. Provision of daily living needs.

2.2.4.10.4. Safety assessments.

2.2.5. The Contractor shall provide or arrange for the following Non-State Plan (1915(b)(3) Waiver services) to Members:

2.2.5.1. Vocational Services.

2.2.5.2. Intensive Case Management.

2.2.5.3. Prevention/Early Intervention Activities.

2.2.5.4. Clubhouse and Drop-in Centers.

2.2.5.5. Residential.

2.2.5.6. Assertive Community Treatment (ACT).

2.2.5.7. Recovery Services.

2.2.5.8. Respite Services.

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

2.2.7. The Contractor shall provide the services listed in Section 2.2 in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under fee-for-service Medicaid.

2.2.8. The Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

2.2.9. The Contractor is prohibited from arbitrarily denying or reducing the amount, duration or scope of a required service solely because of the diagnosis, type of illness, or condition.

2.2.10. The Contractor may place appropriate limits on a service:

2.2.10.1. On the basis of criteria applied under the Medicaid State Plan, such as medical necessity.

2.2.10.2. For utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

2.3. EVIDENCE-BASED AND PROMISING PRACTICES

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

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

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

2.3.1.2. Evidence-based and Promising Practices for Adults

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

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

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

2.3.1.2.2. Adult Services

2.3.1.2.2.1. Assertive community treatment.

2.3.1.2.2.2. Co-occurring disorders.

2.3.1.2.2.3. Member-run/Peer Services.

2.3.1.2.2.4. Emergency/Crisis services.

2.3.1.2.2.5. Illness management.

2.3.1.2.2.6. Psychiatric rehabilitation.

2.3.1.2.2.7. Psycho-education for families.

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

2.3.1.2.2.9. Supported employment.

2.3.1.2.2.10. Supported housing.

2.3.1.2.2.11. Adult behavioral health promotion.

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

2.3.1.2.3.1. DELIVERABLE: Evidence Based Practices Spreadsheet.

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

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

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

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

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

2.3.1.3.2. Children and Adolescent Services

2.3.1.3.2.1. Brief hospitalization for suicidal children and adolescents.

2.3.1.3.2.2. Crisis services.

2.3.1.3.2.3. Family therapy.

2.3.1.3.2.4. Psychotherapy for children and adolescents.

2.3.1.3.2.5. Home-based services.

2.3.1.3.2.6. Intensive case management.

2.3.1.3.2.7. Psycho education.

2.3.1.3.2.8. School-based services.

2.3.1.3.2.9. Behavioral health prevention interventions.

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

2.3.1.3.3.1. DELIVERABLE: Evidence Based Practices Spreadsheet.

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

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

2.4. INTEGRATED AND COORDINATED CARE

2.4.1. Innovations Program for Integrating Care

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

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

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

2.4.2. Coordination and Continuity of Care

2.4.2.1. Policies and Procedures

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

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

2.4.2.1.1.2. Service accessibility.

2.4.2.1.1.3. Attention to individual needs.

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

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

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

2.4.2.2. Care Coordination Activities

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

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

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

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

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

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

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

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

2.4.2.3. Strategies for Advancing Integration

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

2.4.2.4. Special Populations and Complex Members

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

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

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

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

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

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

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

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

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

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

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

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

2.4.2.4.2.2. Dually or multi-eligible Members

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

2.4.2.4.2.3. Dually or multi- diagnosed Members

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

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

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

2.4.2.4.2.4. Members with special health care needs

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

2.4.2.4.2.5. Members involved with the correctional system

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

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

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

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

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

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

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

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

2.4.2.4.2.5.6.1. DELIVERABLE: Correctional System Strategies and Techniques.

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

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

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

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

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

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

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

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

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

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

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

2.4.2.4.2.8.4.2. Discharge planning meetings.

2.4.2.4.2.8.4.3. Face-to-face planning with member.

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

2.4.2.4.2.8.5. Once the Contractor's Members are discharged from an Institute, the Contractor shall be responsible for on-going treatment, case management and other behavioral health services determined to be medically necessary.

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

2.4.2.5. Community Partners

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

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

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

2.4.2.5.2.2. DUE: Annually on August 30th.

2.4.2.6. Alignment with Systems

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

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

2.4.2.6.1.2. Colorado Department of Human Services, Child Welfare.

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

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

2.4.2.6.1.5. Colorado Department of Public Health and Environment.

2.4.2.6.1.6. Colorado Department of Corrections

2.4.2.6.1.7. Colorado Prevention Services Division

2.4.2.7. Program Improvement Advisory Committee

2.4.2.7.1. The Contractor shall create a Program Improvement Advisory Committee (PIAC) to provide input into the Contractor's implementation of the Program and the Contractor's own performance improvement program. The PIAC shall:

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

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

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

2.4.2.7.1.3.1. Members

2.4.2.7.1.3.2. Members' families

2.4.2.7.1.3.3. Advocacy groups and organizations

2.4.2.7.1.3.4. Network provider representatives

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

2.4.2.7.1.3.6. Other Medicaid providers

2.4.2.7.1.3.7. Nursing Facilities/Assisted Living Residences

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

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

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

2.4.2.7.1.5. Open all scheduled meetings to the public.

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

2.4.2.7.1.6.1. DELIVERABLE: Program Improvement Advisory Committee Minutes.

2.4.2.7.1.6.2. DUE: Within ten (10) days of each meeting.

2.5. SERVICE DELIVERY

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

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

2.5.2.1. Community Mental Health Centers (CMHC).

2.5.2.2. Essential Community Providers (ECP).

2.5.2.2.1. The Contractor shall offer contracts to all ECPs located in the Contract Service Area. The Contractor is not required to contract with every ECP that provides behavioral health services in its geographic area, as defined in Section 25.5-5-404.2 C.R.S.

2.5.2.3. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

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

2.5.2.3.2. FQHC and RHC Encounter Reimbursement

2.5.2.3.2.1. Payments from Contractor to FQHC and RHC Facilities

2.5.2.3.2.1.1. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 8.7006C.

2.5.2.3.2.1.2. The Department shall notify the Contractor of the current FQHC and RHC rates on a no less than quarterly basis.

2.5.2.3.2.1.3. The Contractor shall reimburse the FQHC and RHC, at a minimum, an encounter rate in accordance with 10 CCR 2505-10 8.700.6 and the Medicaid State Plan for each FQHC and RHC visit, for services identified in 10 CCR 2505-10 8.700.3 for allowable costs identified in 10 CCR 2505-10 8.700.5. The Department will conduct quarterly accuracy audits with FQHCs and RHCs and should the Department recognize any discrepancy in FQHC and RHC payments (less than the full encounter rate), then the Contractor shall be responsible for reimbursing the FQHC and RHC the difference of the encounter payment identified in 2.5.2.3.2.1.1 and the initial reimbursement amount.

2.5.2.3.2.1.4. The Contractor shall participate in the Department's accuracy audits process of FQHCs and RHCs and is required to complete the documentation located at (https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms) upon the Department's request.

2.5.2.3.2.2. An FQHC and RHC visit is defined in 10 CCR 2505-10 8.700.1.

2.5.2.3.2.3. If multiple services are provided by an FQHC and RHC within one visit, the Contractor will require a claims submission from the FQHC and RHC with multiple lines of services and the same claim number. The Contractor is required to pay the FQHC and RHC no less than the encounter rate minus any third party payments for each visit.

2.5.2.3.3. The Contractor will submit the encounter data for FQHC and RHC visits to the Department.

2.5.2.4. School Based Health Centers (SBHCs).

2.5.2.5. Rural health clinics.

2.5.2.6. Community safety net clinics.

2.5.2.7. Substance use disorder providers.

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

2.5.2.9. Providers capable of billing both Medicare and Medicaid.

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

2.5.3.1. DELIVERABLE: Provider Credentialing System.

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

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

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

2.5.5.1. Specific mechanisms for individual Member intake and assessment.

2.5.5.2. Service planning.

2.5.5.3. Care coordination.

2.5.5.4. Continuity of care.

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

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

2.5.8. Access to Care

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

2.5.8.1.1. Varied geographic location of providers.

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

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

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

2.5.8.1.5. Community-based access.

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

2.5.8.1.5.1.1. Schools.

2.5.8.1.5.1.2. Juvenile detention centers.

2.5.8.1.5.1.3. Federally qualified health centers.

2.5.8.1.5.1.4. Homeless shelters.

2.5.8.1.5.1.5. Acute care facilities.

2.5.8.1.5.1.6. Nursing facilities and assisted living residences.

2.5.8.1.5.1.7. Members' homes.

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

2.5.8.1.7. Member Call-In Services

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

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

2.5.8.1.7.2.1. DELIVERABLE: Call Center Policies and Procedures.

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

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

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

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

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

2.5.8.1.7.4.3. Member identification.

2.5.8.1.7.4.4. Reason for Member's call.

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

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

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

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

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

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

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

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

2.5.8.1.10. Criteria for discharge from treatment/services.

2.5.8.1.10.1. The Contractor shall establish clear and specific criteria for discharging Members from treatment. Criteria shall be included in Member materials and information. Individualized criteria for discharge agreed upon by Member and Provider shall be noted in the Member's health care record and modified, by agreement, as necessary.

2.5.8.1.11. Standards for timeliness of service include:

2.5.8.1.11.1. Emergency services shall be available by phone, including TTY accessibility, within fifteen (15) minutes of the initial contact, in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours of contact in rural and frontier areas.

2.5.8.1.11.2. Care for an urgent medical condition shall be available within twenty-four (24) hours from the initial identification of need.

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

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

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

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

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

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

2.5.8.1.11.8. The Contractor shall monitor providers regularly to determine compliance with the timely access requirements.

2.5.8.1.11.8.1. The Contractor shall take corrective action if it, or its providers, fail to comply with the timely access requirements.

2.5.8.1.11.9. The Contractor and its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.

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

2.5.8.1.11.10.1. DELIVERABLE: After Hour Authorization Process.

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

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

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

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

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

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

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

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

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

2.5.8.1.11.15. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

2.5.8.1.11.16. The Contractor shall consult with the requesting provider on authorization decisions, when appropriate.

2.5.8.2. The Contractor shall provide for a Member to receive a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the Member

2.5.9. Provider Network

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

2.5.9.1.1. A comprehensive Provider Network shall take into account:

2.5.9.1.1.1. The anticipated Medicaid enrollment.

2.5.9.1.1.2. The expected utilization of services.

2.5.9.1.1.3. Standards of appropriate case load for providers.

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

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

2.5.9.2.1. The numbers, types and specialties of providers, particularly substance use disorder providers, psychiatrists and child psychiatrists, and those who serve children in the child welfare system, required to furnish covered services and care coordination.

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

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

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

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

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

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

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

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

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

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

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

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

2.5.9.2.13. The number of providers in the Contractor's network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the Contractor's region.

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

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

2.5.9.2.14.1.1. Access to Care standards.

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

2.5.9.2.14.1.3. BHO responsibilities and services to the community.

2.5.9.2.14.1.4. Grievances, appeals, and member rights.

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

2.5.9.2.15. DELIVERABLE: Network Plan.

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

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

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

2.5.9.5. If the Contractor is unable to provide covered services to a particular Member within its network, the Contractor shall adequately and timely provide the covered services out of network at no cost to the Member. The Contractor shall maintain co-location of staff in high volume physical health locations and support smaller, dispersed physical health providers with the behavioral health needs of their covered population.

2.5.9.6. The Contractor shall establish relationships with and offer to contract with RCCOs. The Contractor shall coordinate care with a network of specialty providers including but not limited to RCCOs, CCBs, DD/TBI/autism providers, SBHCs, FQHCs, rural health clinics, community safety net clinics, and other Essential Community Providers.

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

2.5.9.7.1. DELIVERABLE: Patient Load Monitoring Plan.

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

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

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

2.5.9.10. Trauma Informed Care

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

2.5.9.10.1.1. A system wide understanding of trauma prevalence.

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

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

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

2.5.9.11. Treatment Foster Care

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

2.5.9.11.1.1. Adequacy shall be determined by the Department based upon information provided by the Contractor and counties. The Contractor's documentation shall include the number of children in foster care needing services and capacity of the Contractor's providers in their network.

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

2.5.10. Intake and Assessment

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

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

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

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

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

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

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

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

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

2.5.11. Service Planning

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

2.5.11.1.1. Measurable treatment goals.

2.5.11.1.2. Strategies to achieve the stated goals, including amount, frequency, and duration.

2.5.11.1.3. A schedule for reassessing service plan goals.

2.5.11.1.3.1. Service planning shall take place at least annually or when there is a change in the Member's level of functioning and care needs.

2.5.11.2. The Contractor shall create an individualized, culturally sensitive service plan, developed by the Member and/or the designated Member representative and the Member's provider or treatment team for each Member seeking services. The service plan shall utilize the Member's strengths, and shall be signed by the Member as well as the reviewing professional.

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

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

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

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

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

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

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

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

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

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

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

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

2.5.12. Cultural Competency

2.5.12.1. The Contractor shall facilitate the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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

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

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

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

2.5.12.2.1.3. DELIVERABLE: Cultural Competency Plan.

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

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

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

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

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

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

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

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

2.5.12.2.4.1. DELIVERABLE: Initial Organizational Self-Assessment.

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

2.5.12.2.4.3. DELIVERABLE: Annual Organizational Self-Assessment.

2.5.12.2.4.4. DUE: Annually by December 31st

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

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

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

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

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

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

2.5.12.3. Translation for Oral and Written Communications

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

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

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

2.5.12.3.3. The Contractor shall provide verbal offers to Members informing them of their right to receive language assistance services in their preferred prevalent non-English language as set forth in Section 2.6.9.5. of the Contract. The Contractor shall provide written notices of this right to Members in their preferred prevalent non-English language, upon request.

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

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

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

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

2.5.12.3.6.1.1. DELIVERABLE: Interpreter Policies and Procedures.

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

2.5.13. Early and Periodic Screening, Diagnostic and Treatment Services

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

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

2.5.13.2. EPSDT includes, but is not limited to:

2.5.13.2.1. Screening.

2.5.13.2.2. Vision.

2.5.13.2.3. Dental.

2.5.13.2.4. Hearing.

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

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

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

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

2.5.14. Provider Applications

2.5.14.1. The Contractor shall not discriminate with regards to the participation, reimbursement or indemnification of any Provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. If the Contractor declines to include an individual Provider or group of Providers in its network, it shall give the affected Providers written notice of the reasons for its decision. In no event shall this provision be construed to:

2.5.14.1.1. Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members.

2.5.14.1.2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

2.5.14.1.3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

2.5.15. Service Authorizations

2.5.15.1. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed fourteen (14) days after receipt of a request for service, with a possible extension of fourteen (14) days if the Member or provider requests and extension or the Contractor justifies the need for additional information and how the extension is in the Member's interest.

2.5.15.2. When a provider indicates, or the Contractor determines, that following the standard authorization decision timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) working days after receipt of the request for the service.

2.5.15.2.1. The three (3) working day period may be extended by up to fourteen (14) days if the member requests an extension or the Contractor justifies a need for additional information and is able to demonstrate how the extension is the Member's best interest.

2.5.15.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than request, must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

2.5.15.4. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for denying, limiting, or discontinuing medically necessary services to any member.

2.6. MEMBER AND FAMILY AFFAIRS

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

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

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

2.6.1.2.1. Member recovery

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

2.6.1.2.3. The responsibilities of handling grievances and appeals.

2.6.1.2.4. Providing federally-required Member information.

2.6.1.2.5. Communicating and upholding Member rights.

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

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

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

2.6.5. Grievances and Appeals

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

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

2.6.5.3. The Contractor shall, at the time they enter into a contract, inform Providers and subcontractors about:

2.6.5.3.1. The Member's right to a state fair hearing, how Members obtain a hearing, and the representation rules at a hearing.

2.6.5.3.2. The Member's right to file grievances and appeals, including but not limited to:

2.6.5.3.2.1. The requirements and time frames for filing.

2.6.5.3.2.2. The availability of assistance with filing.

2.6.5.3.2.3. The toll-free number to file orally.

2.6.5.3.3. The Member's right to request a continuation of benefits during an appeal or state fair hearing filing, although the member may be liable for the cost of any continued benefits if the action is upheld.

2.6.5.3.4. Any State-determined Provider's appeal rights to challenge the failure of the organization to cover a service.

2.6.5.4. The Contractor shall allow a Member to file a grievance either orally or in writing and shall acknowledge receipt of each grievance.

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

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

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

2.6.5.4.3.1. A grievance regarding denial of expedited resolutions of an appeal.

2.6.5.4.3.2. Any grievance involving clinical issues.

2.6.5.4.3.3. An appeal of a denial that is based on lack of medical necessity.

2.6.5.5. The Contractor's notice of adverse action shall:

2.6.5.5.1. Be in writing.

2.6.5.5.2. Be available in the state-established prevalent non-English languages in its service area.

2.6.5.5.3. Be available in alternative formats for persons with special needs.

2.6.5.5.4. Use easily understood language and format.

2.6.5.5.5. Give notice:

2.6.5.5.5.1. At least ten (10) days before the date of action, when the action is a termination, suspension or reduction of previously authorized Medicaid-covered services.

2.6.5.5.5.2. As few as five (5) days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud.

2.6.5.5.5.3. By the date of action when any of the following occur:

2.6.5.5.5.3.1. The recipient has died.

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

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

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

2.6.5.5.5.3.5. The member's address is determined unknown based on returned mail with no forwarding address.

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

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

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

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

2.6.5.5.5.4. On the date of action when the action is a denial of payment

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

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

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

2.6.5.5.5.5.3. For cases in which a Provider, or the Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or his/her ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) working days after receipt of the request for service.

2.6.5.5.5.5.4. The Contractor may extend the three (3) working day expedited service authorization decision time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest.

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

2.6.5.5.6. Explain all of the following:

2.6.5.5.6.1. The action the Contractor or its subcontractor has taken or intends to take.

2.6.5.5.6.2. The reasons for the action.

2.6.5.5.6.3. The Member's right to file an appeal; or the Provider's right to file an appeal when the Provider is acting on behalf of the Member as the Member's Designated Client Representative.

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

2.6.5.5.6.5. Procedures for exercising Member's rights to appeal or grieve.

2.6.5.5.6.6. Circumstances under which expedited resolution is available and how to request it.

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

2.6.5.6. The Contractor shall allow Member's and Providers, acting on behalf of the Member and with the Member's written consent, to file appeals:

2.6.5.6.1. Within thirty (30) calendar days from the date of the Contractor's notice of action.

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

2.6.5.7. The Contractor shall ensure that oral inquiries seeking to appeal an action are treated as appeals, and confirmed in writing unless the Member or the Provider requests expedited resolution.

2.6.5.8. If the Member, or Provider acting on behalf of the Member, orally requests an expedited appeal, the Contractor shall not require a written, singed appeal follow.

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

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

2.6.5.11. The Contractor shall allow the Member and his/her representative opportunity, before and during the appeals process, to examine the Member's case file, including medical records and any other documents and records.

2.6.5.12. The Contractor shall consider the Member, his/her representative, or the legal representative of a deceased Member's estate as parties to an appeal.

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

2.6.5.14. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the standard timeframe of no longer than forty-five (45) days from the day the MCE receives the appeal (with a possible fourteen (14) day extension); and give the Member prompt oral notice of the denial and a written notice within two (2) calendar days.

2.6.5.15. The Contractor shall resolve each expedited appeal and provide notice, as expeditiously as the Member's health condition requires, within state-established timeframes not to exceed three (3) working days after the Contractor receives the expedited appeal request.

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

2.6.5.17. The Contractor shall provide the Member with written notice of the reason for any extension to the timeframe for processing an expedited appeal that is not requested by the Member.

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

2.6.5.19. The Contractor shall resolve each appeal and provide notice, as expeditiously as the Member's health condition requests, within the State-established timeframes not to exceed forty-five (45) days from the day the Contractor receives the appeal.

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

2.6.5.21. The Contractor shall provide the Member with written notice of the reason for any extension to the timeframe for processing an appeal that is not requested by the Member.

2.6.5.22. The Contractor shall provide written notice of the disposition of the appeals process, which must include the results and data of the appeal resolution.

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

2.6.5.23.1. Right to request a State Fair Hearing.

2.6.5.23.2. How to request a State Fair Hearing.

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

2.6.5.23.4. Notice that the member may be liable for the cost of any continued benefits if the Contractor's action is upheld in the hearing.

2.6.6. Continuation of Benefits and Services

2.6.6.1. The Contractor shall continue the Member's benefits while an appeal is in the process if all of the following are met:

2.6.6.1.1. The appeal is filed on or before the later of the following:

2.6.6.1.1.1. Within ten (10) days of the Contractor mailing the notice of action.

2.6.6.1.1.2. The intended effective date of the Contractor's proposed action

2.6.6.1.2. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.

2.6.6.1.3. The services were ordered by an authorized Provider.

2.6.6.1.4. The authorization period has not expired.

2.6.6.1.5. The Member requests an extension of benefits.

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

2.6.6.2.1. The Member withdraws the appeal.

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

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

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

2.6.6.3. The Contractor may recover the cost of the continued services furnished to the Member while the appeal was pending if the final resolution of the appeal upholds the Contractor's action.

2.6.6.4. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services were not furnished while the appeal was pending and if the Contractor or State Fair Hearing Officer reverses a decision to deny, limit, or delay services.

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

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

2.6.6.7. Members may file a grievance either orally or in writing with the Contractor and/or the Department.

2.6.6.8. The Contractor shall dispose of each grievance and provide notice, as expeditiously as the Member's health condition requires, with State-established timeframes not to exceed ninety (90) days from the day the Contractor receives the grievance.

2.6.7. State Fair Hearing

2.6.7.1. Members may request a State Fair Hearing within thirty (30) days from the date on the Contractor's notice of action.

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

2.6.7.3. The State's standard timeframe for reaching its decision on a state fair hearing request is within ninety (90) days of the date the Member filed the appeal with the Contractor if the Member filed initially with the Contractor, excluding the days the Member took to subsequently file for a State Fair Hearing, or the date the Member filed for direct access to a State Fair Hearing.

2.6.8. Expedited State Fair Hearing

2.6.8.1. When the appeal is heard first through the Contractor's appeal process, the Office of Appeals shall issue a Final Agency Decision for an expedited State Fair Hearing decision as expeditiously as the Member's health condition requires, but no later than three (3) working days from the Department receipt of a hearing request for a denial of service that:

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

2.6.8.1.2. Was resolved wholly or partially adversely to the enrollee using the Contractor's expedited appeal timeframes.

2.6.8.2. When the appeal is made directly to the State Fair Hearing process without accessing the Contractor's appeal process, the Office of Appeals shall issue a Final Agency Decision for an expedited State Fair Hearing decision as expeditiously as the Member's health condition requires, but no later than three (3) working days form the Department's receipt of a hearing request for a denial of a service that meets the criteria for an expedited resolution.

2.6.9. Member Services

2.6.9.1. Policies and Procedures

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

2.6.9.2. Member Input

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

2.6.9.3. Cultural Competency

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

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

2.6.9.3.2. The Contractor shall provide language assistance services when a Member asks. The Contractor shall also make verbal offers and provide written notices to Members informing them of the right to receive language assistance services. The services shall be given in the prevalent non-English languages as established by the State.

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

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

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

2.6.9.4. Wraparound Benefits

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

2.6.9.5. Prevalent Languages

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

2.6.9.6. Alternative Formats

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

2.6.9.7. Member Handbook

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

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

2.6.9.7.2.1. For purposes of this requirement, a substantial change is one that would impact a member's ability to obtain services or exercise their rights.

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

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

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

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

2.6.9.7.7. If the Department ceases to delegate Member handbook responsibilities to the Contractor pursuant to this Contract during the contract period, the Department will issue notice to the Contractor. Notwithstanding the foregoing, the Contractor shall continue to make the information contained in the Member handbook available on the Contractor's web site for viewing.

2.6.9.8. Provider Directory (Web Version)

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

2.6.9.9. Notice of Privacy Practices

2.6.9.9.1. Upon initial enrollment, and annually thereafter, the Contractor shall distribute to each Member a copy of the notice of privacy practices. The notice shall comply with 45 CFR 164.520.

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

2.6.9.10. Advance Directives

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

2.6.9.10.1.1. A description of applicable State law.

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

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

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

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

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

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

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

2.6.9.11. Distribution of Statements

2.6.9.11.1. The Contractor shall distribute statements of Members' rights and responsibilities to Members in the Member Handbook. The Contractor shall post these Statements on its website.

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

2.6.9.12. Distribution of Practice Guidelines

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

2.6.9.13. Member Materials

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

2.6.9.13.2. The Contractor shall ensure that all vital materials are translated into the prevalent languages in Section 2.6.9.5. of the Contract and are available for immediate dissemination in that language.

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

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

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

2.6.10. Member Rights

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

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

2.6.10.2.1. Stakeholders.

2.6.10.2.2. Providers.

2.6.10.2.3. Member's families.

2.6.10.2.4. Members.

2.6.10.2.5. Case workers.

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

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

2.6.11. Member Information

2.6.11.1. The Contractor shall provide Member information that includes, but is not limited to:

2.6.11.1.1. The names, locations, telephone numbers or, and non-English languages spoken by current contracted providers in the Enrollee's service area, including identification of providers that are not accepting new patients. This includes at a minimum, information specialists and hospitals.

2.6.11.1.2. Any restrictions on the Enrollee's freedom of choice among network providers.

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

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

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

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

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

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

2.6.11.1.9. Freely exercise his or her rights with the Contractor or its providers treating the Enrollee adversely.

2.6.11.1.10. The amount, duration, and scope of benefits available under the contracts in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled.

2.6.11.1.11. Procedures for obtaining benefits, including authorization requirements.

2.6.11.1.12. Extent to which, and how, Enrollees may obtain benefits from out-of-network providers.

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

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

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

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

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

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

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

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

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

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

2.6.11.1.15. An explanation that the Member will not be responsible for fees or copayments for services covered by the Contract.

2.6.11.2. In accordance with Section 2.6.5. of this Contract the Contractor shall provide information to Members on grievance, appeal and state fair hearing procedures and timelines. The description shall include at least the following:

2.6.11.2.1. Enrollees' rights to a state fair hearing.

2.6.11.2.2. The method for obtaining a state fair hearing.

2.6.11.2.3. The rules that govern representation at the state fair hearing.

2.6.11.2.4. Member's right to file grievances and appeals.

2.6.11.2.5. Requirements and timeframes for filing a grievance or appeal.

2.6.11.2.6. Availability of assistance for filing a grievance, appeal, or state fair hearing.

2.6.11.2.7. The toll free number the enrollee can use to file a grievance or appeal by phone.

2.6.11.2.8. The fact that benefits will continue, when requested by the Member, if the Member files a timely appeal or state fair hearing request.

2.6.11.2.8.1. If the action is upheld the Member may be liable for the cost of any continued benefits.

2.6.11.2.9. Any appeal rights the State makes available to providers to challenge the failure of the organization to cover a service.

2.6.11.3. The Contractor shall provide other necessary information to Members and their families, as determined by the Department. This information shall include, but not be limited to:

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

2.6.11.3.2. EPSDT.

2.6.11.3.3. Community resources.

2.6.11.3.4. Member rights.

2.6.11.4. Upon request the Contractor shall provide information on the structure and operation of the Contractor.

2.6.12. Ombudsman for Medicaid Managed Care

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

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

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

2.6.12.3.1. DELIVERABLE: Ombudsman Policy.

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

2.6.13. Website

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

2.6.13.1.1. Contractor's contact information.

2.6.13.1.2. Member rights and handbooks.

2.6.13.1.3. Grievance and appeal procedures and rights.

2.6.13.1.4. General functions of the Contractor.

2.6.13.1.5. Trainings.

2.6.13.1.6. Provider directories and contact information.

2.6.13.1.7. Access to care standards.

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

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

2.6.14. Provider Termination

2.6.14.1. The Contractor shall make a good faith effort to give written notice within fifteen (15) days when a member's primary care Provider (or a Provider that they saw on a regular basis) terminates.

2.7. REGION SPECIFIC REQUIREMENTS

2.7.1. Integration

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

2.7.1.1.1. Develop an Integrated Health Care Collaborative that will disseminate the knowledge, resources, and skills required to implement best practices in integrated health care.

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

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

2.7.2.1.1. Hold quarterly meetings with the assisted living residences and nursing facilities in the region to address systems issues and concerns.

2.7.2.1.2. Conduct an annual survey of Members in long-term care and nursing facilities and of the nursing facility and assisted living residence staff, focusing on the degree to which clients and facility staff agree clients receive access to and appropriate behavioral health services.

2.7.3. Members involved with the Correctional System

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

2.7.3.1.1. Monitor access and care coordination for individuals transitioning from criminal justice facilities to the community.

2.7.3.1.1.1. Quarterly reports shall measure the time from initial contact to actual initial appointment, along with routine measures of access, medical records audits assessing care coordination, and examination of trends in grievances.

2.7.3.1.1.2. The Contractor shall submit this report to the Department every quarter within five (5) Business Days after it has been finalized by the Contractor.

2.7.3.1.1.2.1. DELIVERABLE: Quarterly Access and Care Coordination Report.

2.7.3.1.1.2.2. DUE: Within five (5) Business Days after it has been finalized by the Contractor.

2.7.4. Service Planning

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

2.7.4.1.1. Convene local workgroups to delineate and refine the referral process for children with positive trauma screens. This may include a referral form, documented procedures related to releases of information, parental outreach, and a system of information exchange.

2.8. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

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

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

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

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

2.8.4. Practice Guidelines

2.8.4.1. The Contractor shall adopt practice guidelines that consider the needs of its Members and are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

2.8.4.2. The Contractor shall adopt, and update periodically as appropriate, practice guidelines in consultation with contracting healthcare professionals.

2.8.4.3. The Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.

2.8.4.4. Decisions regarding utilization management, member education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines.

2.8.5. Performance Improvement Projects

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

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

2.8.5.1.1.1. Measurement and intervention to achieve significant improvement, where mathematically possible, sustained over time in clinical and non-clinical care areas expected to have a favorable effect on health outcomes and member satisfaction.

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

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

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

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

2.8.5.1.1.6. Empirical evaluation of the effectiveness of the interventions.

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

2.8.6. Performance Incentives

2.8.6.1. The Contractor shall work with the Department to develop a mutually agreed upon performance incentive program that is minimally based on the performance measures in Exhibit F of the Contract.

2.8.6.1.1. Initiation of the mutually agreed upon performance incentive program is at the sole discretion of the Department.

2.8.7. Performance Measures

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

2.8.8. RCCOs and physical health/integration efforts and outcomes

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

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

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

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

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

2.8.8.2. DELIVERABLE: Integration Report.

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

2.8.9. Colorado Client Assessment Record

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

2.8.9.1.1. An "admission" CCAR must be completed upon a Member receiving:

2.8.9.1.1.1. Six (6) or more brief integrated mental and physical health service encounters during any continuous six-month period.

2.8.9.1.1.2. Four (4) or more mental health service encounters during any continuous six-month period in a non-integrated care setting.

2.8.9.1.2. The procedure codes listed in Exhibit J do not count toward the total number of services received within a six-month period.

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

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

2.8.10. Member Satisfaction

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

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

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

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

2.8.11. Quality of Care Issues

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

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

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

2.8.11.2.2. Investigating the QOC issue(s).

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

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

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

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

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

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

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

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

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

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

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

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

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

2.8.11.2.8.5. Evidence of the QOC resolution.

2.8.11.2.8.6. A copy of the acknowledgement and resolution letters.

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

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

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

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

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

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

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

2.8.11.4.4. The complete letter shall be sent to the Department within ten (10) Business Days of the Department's request. Upon request from the Contractor, the Department may allow additional time to investigate and report.

2.8.11.4.4.1. DELIVERABLE: QOC Description Letter.

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

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

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

2.8.11.5.2. DELIVERABLE: Quality of Care Concerns Process.

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

2.8.12. Quality Improvement Committee

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

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

2.8.13. Health Information Systems

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

2.8.13.1.1. Utilization.

2.8.13.1.2. Grievances and appeals.

2.8.13.1.3. Third party liability.

2.8.13.1.4. Disenrollments for other than loss of Medicaid eligibility.

2.8.13.2. The Contractor shall screen the data received from Providers for completeness, logic and consistency.

2.8.13.3. The Contractor shall verify the accuracy and timeliness of data reported by Providers.

2.8.13.4. The Contractor shall collect service information from Providers in standardized formats to the extent feasible and appropriate.

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

2.8.13.5.1. DEVLIVERABLE: Health Information Data.

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

2.8.14. External Quality Review (EQR)

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

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

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

2.8.15. Annual Quality Report

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

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

2.8.15.2.1. DELIVERABLE: Annual Report.

2.8.15.2.2. DUE: Annually, by September 30th.

2.8.16. Quality Improvement Plan

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

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

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

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

2.8.16.1.3.1. DELIVERABLE: Quality Improvement Plan.

2.8.16.1.3.2. DUE: Annually, by September 30th.

2.8.17. Ad Hoc Reporting

2.8.17.1. The Contractor may be required to provide information or data relative to the Contract to the Department or its agents. In such instances, and at the direction of the Department, the Contractor shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested. The Contractor shall have at least thirty (30) calendar days, or a timeframe mutually agreed upon between the Department and the Contractor, to fulfill such requests. The Contractor shall certify that data and information it submits to the Department is accurate.

2.9. COMPLIANCE AND MONITORING

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

2.9.2. Utilization Management

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

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

2.9.3. Program Integrity

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

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

2.9.3.1.1.1. Provisions for internal monitoring and auditing.

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

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

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

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

2.9.3.1.1.6. Processes to comply with Section 2.9.7.4.3.

2.9.3.1.1.6.1. DELIVERABLE: Compliance Program Plan.

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

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

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

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

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

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

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

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

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

2.9.3.5. The Contractor may, on its own initiative, suspend payment to any Participating Provider against whom there is a credible allegation of fraud, but only after consultation with the Department and the Medicaid Fraud Control Unit. The Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

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

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

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

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

2.9.3.8.1. DELIVERABLE: Member Services Verification Plan.

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

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

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

2.9.3.10.1. DELIVERABLE: Notification of Adverse Action.

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

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

2.9.3.11.1. DELIVERABLE: Notification of Adverse Action Procedures.

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

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

2.9.4. Encounter Data

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

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

2.9.4.1.1.1. DELIVERABLE: Encounter Data Report.

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

2.9.4.2. The Contractor shall submit monthly data certifications for all flat-file data utilized for the purposes of rate setting (42 C.F.R. 438.604 and 438.606). Data certification shall include certification that data submitted is accurate, complete and truthful, and that all "paid" encounters are for covered services provided to or for enrolled Members.

2.9.4.2.1. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

2.9.4.2.2. DELIVERABLE: Data Certifications.

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

2.9.4.3. The Contractor shall submit its raw encounter data, excluding data protected by 42 CFR Part 2, to the Colorado All-Payer Claims Database (APCD) in accordance with the guidelines found in the most current version of the *Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide* found at http://www.colorado.gov/hcpf.

2.9.4.3.1. The data submitted to the APCD will be used in the calculation of performance measures.

2.9.4.3.2. DELIVERABLE: APCD Encounter Data Submission

2.9.4.3.3. DUE: On the last day of the month following the month in which the data was collected.

2.9.4.4. The Contractor is required to submit all Encounter Claims Data electronically, following the Colorado Medical Assistance Program policy rules found in *Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations)* or in the *Colorado Code of Regulations (10 CCR 2505-10).* Encounter data shall be submitted in the ANSI ASC X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837 format encounter claims, reflecting paid and/or adjusted by the Contractor shall be submitted via a regular monthly batch process. All encounter claims shall be submitted in accordance with the following:

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

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

2.9.4.4.3. 837 X12N Companion Guide Specifications available at: http://www.colorado.gov/hcpf.

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

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

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

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

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

2.9.4.7.3. Daily generated PHP Disenrollment Report (R0305)

2.9.4.7.4. Monthly generated PHP Disenrollment Report (M0305)

2.9.4.7.5. Monthly generated PHP Enrollment Change Report (R0310)

2.9.4.7.6. Monthly generated PHP Current Membership Report (R0315)

2.9.4.7.7. Daily generated PHP New Membership Report (R0325)

2.9.4.7.8. Monthly generated PHP New Membership Report (M0325)

2.9.4.7.9. Monthly generated PHP Capitation Summary Report (R0360)

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

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

2.9.5. Compliance Reporting

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

2.9.6. Maintenance of Records

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

2.9.7. Physician and Individual Provider Credentialing and Monitoring

2.9.7.1. Policies and Procedures

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

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

2.9.7.1.2.1. The frequency of monitoring.

2.9.7.1.2.2. How providers are selected to be reviewed.

2.9.7.1.2.3. Scoring benchmarks.

2.9.7.1.2.4. The way record samples will be chosen.

2.9.7.1.2.5. How many records will be reviewed.

2.9.7.1.3. The Contractor's Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

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

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

2.9.7.1.5.1. DELIVERABLE: Provider Credentialing Policies and Procedures.

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

2.9.7.2. Credentialing and Recredentialing

2.9.7.2.1. Credentialing

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

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

2.9.7.2.2. Recruitment

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

2.9.7.2.3. Standards

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

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

2.9.7.2.4. Recredentialing

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

2.9.7.3. Eligibility

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

2.9.7.4. Ongoing Periodic Monitoring at Recredentialing

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

2.9.7.4.2. Cultural Competency

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

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

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

2.9.7.4.3. Affiliations and Employment Oversight

2.9.7.4.3.1. The Contractor shall have an effective mechanism to periodically monitor impermissible affiliations and employees for the duration of the business relationship.

2.9.7.4.3.2. The Contractor shall assure that no Provider has a relationship to individuals who have been disbarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under federal Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2.9.7.4.3.3. The Contractor shall assure that no Provider has a relationship to an affiliate of individuals who have been disbarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities, as defined in the Federal Acquisition Regulation.

2.9.7.4.3.4. The Contractor shall assure that no Provider have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

2.9.7.4.3.5. The Contractor shall assure that no Provider has been terminated by the Department.

2.9.7.4.3.6. The Contractor shall assure that no Provider is excluded by United States Department of Health and Human Services Office of Inspector General and appear on the List of Excluded Individuals and Entities (LEIE).

2.9.7.4.3.7. The Contractor shall assure that no Provider employs or contracts with an individual excluded by United States Department of Health and Human Services Office of Inspector General and appearing on the List of Excluded Individuals and Entities (LEIE).

2.9.7.5. Periodic review of the Monitoring Program

2.9.7.5.1. The Contractor shall periodically (at least bi-annually) evaluate the effectiveness of the Provider monitoring program.

2.9.8. Other Monitoring Activities

2.9.8.1. In consultation with the Department, the Contractor shall participate in and respond to other Department and/or designee compliance monitoring activities, including but not limited to:

2.9.8.1.1. Encounter Data analysis; Encounter Data validation (the comparison of Encounter Data with Medical Records;

2.9.8.1.2. Appeals analysis to identify trends in the Community Behavioral Health Services Program and among behavioral health care organizations; and,

2.9.8.1.3. Other reviews determined by the Department.

2.9.9. Inspection, Monitoring and Site Reviews

2.9.9.1. Contractor shall make staff available to assist in any audit or inspection under the Contract.

2.9.9.2. Contractor shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting all audits, site reviews or inspections.

2.9.9.3. Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

2.9.9.4. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

2.9.10. Site Reviews

2.9.10.1. In addition to the requirements of this Contract, the Contractor shall allow the Department or its designee to conduct site reviews at least annually, or more frequently as determined by the Department.

2.9.10.1.1. Site reviews may include but are not limited to determining compliance with state and federal requirements, contracts and Provider agreements, Medicaid service provision and billing procedures, and Medicaid Bulletins and Provider Manuals. Contractor shall cooperate with Department site review activities to monitor Contractor performance.

2.9.10.2. The Contractor shall allow the Department or its designee to conduct an emergency or unannounced review for instances including but not limited to Member safety, quality of care, potential fraud, or financial viability.

2.9.10.3. For routine site reviews, the Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted for mutually agreed upon dates for a site review. The Contractor shall submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate the Department and/or designee's desk audit prior to the site review.

2.9.10.4. The Contractor shall make available to the Department and/or designee and its agents for site review all records and documents related to the Contract, either on a scheduled basis, or immediately on an emergency or unannounced basis.

2.9.10.5. The Contractor shall respond to any required actions with a corrective action plan within thirty (30) calendar days of the final report, specifying the action to be taken and time frames.

2.9.10.5.1. The corrective action plan shall be submitted to the Department, and is subject to approval by the Department.

2.9.10.5.2. Upon review of the proposed corrective action plan, the Department may require changes to the plan. The Contractor shall make all changes to the plan as required by the Department and resubmit the plan for the Department's approval.

2.9.10.5.3. Once the Department has approved the corrective action plan, the contractor shall implement the plan and the Contractor shall continue to progress via the corrective action plan until the Contractor is found to be in complete compliance by the Department.

2.9.10.5.3.1. DELIVERABLE: Corrective Action Plan.

2.9.10.5.3.2. DUE: Within thirty (30) calendar days of receiving the final report.

2.9.10.6. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during corrective action periods.

2.9.10.7. Site reviews may also include an inspection of Participating Providers in the Contractor's network to ensure that Providers have been educated and monitored by Contractor about the requirements under this Contract, federal and state regulations, and to ensure quality services are being provided to Members. In the event that the Site Reviewers wish to inspect a Provider location, Contractor shall assure that:

2.9.10.7.1. Providers make staff available to assist in the audit or inspection effort.

2.9.10.7.2. Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

2.9.10.8. Financial Records

2.9.10.8.1. The Contractor shall submit annual financial reports to the Department or its designee including but not limited to audited financial statements.

2.9.10.8.2. The Contractor shall submit financial reports and information as requested by the Department or its designee.

2.9.10.8.3. The Contractor shall submit information about financial arrangements with providers in their network to the Department or its designee.

2.9.10.9. Screening of Employees and Contractors

2.9.10.9.1. The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

2.9.10.9.2. The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid.

2.9.10.9.3. If the Contractor determines that one of its employees or contractors has been excluded, then the Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery to the Department within five (5) business days of the date of discovery.

2.9.10.9.3.1. DELIVERABLE: Notification of discovery of excluded employee or contractor.

2.9.10.9.3.2. DUE: Within five (5) business days of the date of discovery.

2.9.11. Federal Financial Participation

2.9.11.1. Federal Financial Participation (FFP) is not available for any amounts paid to the Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

2.9.11.1.1. The Contractor is controlled by a sanctioned individual.

2.9.11.1.2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

2.9.11.1.3. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

2.9.11.1.3.1. Any individual or entity excluded from participation in Federal health care programs.

2.9.11.1.3.2. Any entity that would provide those services through an excluded individual or entity.

2.10. NOTICES AND DISCLOSURES

2.10.1. Actions Involving Licenses, Certifications, Approvals and Permits

2.10.1.1. The Contractor shall notify the Department, within two (2) Business Days, of:

2.10.1.1.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Title 10, Article 16, C.R.S.

2.10.1.1.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

2.10.1.1.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

2.10.1.1.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits.

2.10.1.1.3.2. DELIVERABLE: Within two (2) Business Days of Contractor's notification.

2.10.2. Business Transaction Disclosures

2.10.2.1. The Contractor shall submit, within thirty-five (35) days of the date on a request by the Department or by the Secretary of the Department of Health and Human Services, full and complete information about:

2.10.2.1.1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the 12-month period ending on the date of the request; and

2.10.2.1.2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

2.10.2.2. Significant business transaction means any business transaction or series of transactions that, during any one (1) fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000.00) and five (5) percent of the Contractor's total operating expenses.

2.10.2.3. Wholly owned supplier means a supplier whose total ownership interest is held by the Contractor or by a person, persons, or other entity with an ownership or control interest in the Contractor.

2.10.2.3.1. DELIVERABLE: Business transaction disclosures.

2.10.2.3.2. DUE: Within thirty-five (35) calendar days of the date of a request by the Department or by the Secretary of the Department of Health and Human Services.

2.10.3. Conflict of Interest

2.10.3.1. Notice of a conflict

2.10.3.1.1. The Contractor shall submit a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest, within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.

2.10.3.1.1.1. DELIVERABLE: Conflict of Interest Disclosure Statement.

2.10.3.1.1.2. DUE: Within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.

2.10.3.2. Conflict of interest defined

2.10.3.2.1. The term "conflict of interest" means that:

2.10.3.2.1.1. The Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

2.10.3.2.1.2. The relationship between the third party and the Department is such that one parties' interests could only be advanced at the expense of the others'.

2.10.3.2.1.3. A conflict of interest exists even if the Contractor does not use information obtained from one party in its dealings with the other.

2.10.4. Network Changes and Deficiencies

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

2.10.4.1.1. Information describing how the change will affect service delivery.

2.10.4.1.2. Availability, or capacity of covered services.

2.10.4.1.3. A plan to minimize disruption to the Member care and service delivery.

2.10.4.1.4. A plan for clinical team meetings with the affected Member's to discuss the available options and to revise the service plan to address any changes in services or service providers.

2.10.4.1.5. A plan to correct any network deficiency.

2.10.4.2. DELIVERABLE: Network Change and Deficiency Notification.

2.10.4.3. DUE: Within five (5) Business Days of Contractor becoming aware of the change or deficiency.

2.10.5. Ownership or Control Disclosures

2.10.5.1. Contractor shall disclose to the Department, at the time of executing the Contract with the State, at Contract renewal or extension, within thirty-five (35) calendar days of a written request from the Department, and within thirty-five (35) calendar days after any change in ownership, the following information in a form to be provided by the Department:

2.10.5.1.1. The name and address of any individual or entity with an ownership or control interest in the Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

2.10.5.1.2. Date of birth and Social Security Number of any individual with an ownership or control interest in the Contractor.

2.10.5.1.3. Tax identification number of any corporation or partnership with an ownership or control interest in the Contractor, or in any subcontractor in which the Contractor has a five (5) percent or more interest.

2.10.5.1.4. Whether an individual with an ownership or control interest in the Contractor is related to another person with an ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which the Contractor has a five (5) percent or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.

2.10.5.1.5. The name of any other Medicaid provider (other than an individual practitioner or group of practitioners), fiscal agent, or managed care entity in which an owner of the Contractor has an ownership or control interest.

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

2.10.5.2. The Contractor is prohibited from knowingly having:

2.10.5.2.1. A director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

2.10.5.2.2. A person with ownership or more than five (5) percent or the Contractor's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

2.10.5.2.3. An employment, consulting, or other agreement with an individual or entity for the provision of the contracted items or services who is (or is affiliated with a person or entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

2.10.5.3. Definitions relating to Ownership or Control Disclosures

2.10.5.3.1. Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

2.10.5.3.2. Group of practitioners means two (2) or more health care practitioners who practice their profession at a common location, whether or not they share common facilities, common supporting staff, or common equipment.

2.10.5.3.3. Indirect ownership interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in another entity.

2.10.5.3.4. Ownership interest means the possession of equity in the capital, stock, or profits of an entity.

2.10.5.3.5. Individual or entity with an ownership or control interest means an individual or entity that: has an ownership interest totaling five (5) percent or more; has an indirect ownership interest equal to five (5) percent or more; has a combination of direct and indirect ownership interests equal to five (5) percent or more; owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five (5) percent of the value of the property or assets of the other entity; is an officer or director of an entity that is organized as a corporation; or is a partner in an entity that is organized as a partnership.

2.10.5.3.6. Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation.

2.10.5.3.7. Subcontractor means an individual, agency, or organization to which an entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.

2.10.5.3.7.1. DELIVERABLE: Ownership or Control Disclosures.

2.10.5.3.7.2. DUE: At the time of executing the Contract with the Department, at Contract renewal or extension, and within thirty-five (35) calendar days of either a change of ownership or a written request by the Department.

2.10.5.4. If the Department learns that the Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

2.10.5.4.1. Must notify the Secretary of the noncompliance.

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

2.10.5.4.3. May not renew or extend the existing agreement with the MCE unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

2.10.6. Disclosure of Information on Persons Convicted of Crimes

2.10.6.1. Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date on a written request by the Department, the Contractor shall disclose the identity of any person who:

2.10.6.1.1. Has an ownership or control interest in the Contractor, or who is a managing employee of the Contractor; and

2.10.6.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program.

2.10.6.1.2.1. DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes.

2.10.6.1.2.2. DUE: Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date of a written request by the Department.

2.10.7. Network Provider Ownership or Control Disclosures

2.10.7.1. The Contractor shall require all Providers to disclose to the Contractor, upon submitting the provider application, upon executing the provider agreement, within 35 calendar days of a request by the Department, within thirty-five (35) calendar days of a request by the Contractor, and within thirty-five (35) days after any change in the Provider's ownership, the following information in writing:

2.10.7.1.1. The name and address of any individual or entity with an ownership or control interest in the Provider. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address;

2.10.7.1.2. Date of birth and Social Security Number of any individual with an ownership or control interest in the Provider;

2.10.7.1.3. Tax identification number of any corporation or partnership with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a five (5) percent or more interest;

2.10.7.1.4. Whether an individual with an ownership or control interest in the Provider is related to another person with an ownership or control interest in the Provider as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which the Provider has a 5 percent or more interest is related to another person with ownership or control interest in the Provider as a spouse, parent, child, or sibling;

2.10.7.1.5. The name of any other Medicaid provider (other than an individual practitioner or group of practitioners), fiscal agent, or managed care entity in which an owner of the Provider has an ownership or control interest; and

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

2.10.7.2. The definitions at Section 2.10.5.3 shall apply to these Network Provider Ownership or Control Disclosures.

2.10.7.3. The Contractor shall screen all individuals and entities disclosed under this section against the LEIE. If the Contractor discovers that an individual or entity disclosed under this section has been excluded and appears on the LEIE, then the Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery, in writing, to the Department within five (5) business days of the date of the discovery.

2.10.7.3.1. DELIVERABLE: Notification of Discovery of Excluded Network Provider

2.10.7.3.2. DUE: Within five (5) business days of discovering the exclusion of the Provider.

2.10.8. Network Provider Business Transaction Disclosures

2.10.8.1. The Contractor shall require all Providers to submit in writing, within thirty-five (35) days of the date of a request by the Contractor, by the Department, or the Secretary of the Department of Health and Human Services, to the requesting party, full and complete information about:

2.10.8.1.1. The ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2.10.8.1.2. Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.

2.10.8.1.3. Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of the Provider's total operating expenses.

2.10.8.2. Wholly owned supplier means a supplier whose total ownership interest is held by the Provider, or by a person, persons, or other entity with an ownership or control interest in the Provider.

2.10.8.3. Upon receipt of any such Network Provider Business Transaction Disclosures, the Contractor shall take appropriate action in accordance with federal and state statutes and regulations.

2.10.9. Network Provider Disclosure of Information on Persons Convicted of Crimes

2.10.9.1. The Contractor shall require that, prior to entering into a Provider Agreement with the Contractor, prior to renewing a Provider Agreement with a Provider, within 35 calendar days of a request by the Contractor, and within 35 calendar days of a request by the Department, all Providers disclose the identity of any person who:

2.10.9.1.1. Has an ownership or control interest in the Provider, or who is a managing employee of the Provider; and

2.10.9.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program.

2.10.9.2. Upon receipt of any such disclosure, the Contractor shall take appropriate action in accordance with federal and state statutes and regulations.

2.10.10. Physician Incentive Plans

2.10.10.1. The Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

2.10.10.1.1. Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

2.10.10.2. Physician incentive plans may operate only if no specific payment can be made directly or indirectly under a physician inventive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to a Member.

2.10.10.3. If the Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the Contractor must ensure that the physician or physician group has adequate stop-loss protection.

2.10.11. Policies and Procedures

2.10.11.1. The Contractor shall disclose to the Department copies of any existing policies and procedures related to Section 2.10 of the Contract, upon request by the Department, within ten (10) Business Days.

2.10.11.1.1. DELIVERABLE: Notices and Disclosures Policies and Procedures.

2.10.11.1.2. DUE: Within ten (10) Business Days of the Department's request.

2.10.12. Practice Guidelines

2.10.12.1. The Contractor shall provide practice guidelines to the Department upon request within ten (10) Business Days, and at no cost to the Department.

2.10.12.1.1. DELIVERABLE: Practice Guidelines.

2.10.12.1.2. DUE: Within ten (10) Business Days of the Department's request.

2.10.13. Relationship to Community Mental Health Centers

2.10.13.1. The Contractor shall disclose to the Department at the at the time of contracting, at Contract renewal, and at any time there is a change, the nature and extent of its financial and organizational relationship with the Community Mental Health Centers in its service region.

2.10.14. Security Breaches and HIPAA violations

2.10.14.1. In the event of a breach of the security of sensitive data the Contractor shall immediately notify the Department to report all suspected loss or compromise of sensitive data within five (5) business days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

2.10.14.2. Contractor shall report all HIPAA violations as described in the HIPAA BUSINESS ASSOCIATE ADDENDUM.

2.10.14.2.1. DELIVERABLE: Security and HIPAA Violation Breach Notification.

2.10.14.2.2. DUE: Within five (5) business days of becoming aware of the breach.

2.10.15. Solvency

2.10.15.1. The Contractor shall notify the Department, within two (2) Business Days, of becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards specified in this Contract.

2.10.15.1.1. DELIVERABLE: Solvency Notification.

2.10.15.1.2. DUE: Within two (2) Business Days, of becoming aware of a possible solvency issue.

2.10.15.2. The Contractor shall not hold liable any Member for the Contractor's debts, in the event the Contractor becomes insolvent.

2.10.16. Subcontracts and Contracts

2.10.16.1. The Contractor shall disclose to the Department, within five (5) business days of the Department's request, copies of any existing subcontracts and Contracts with Providers.

2.10.16.1.1. DELIVERABLE: Subcontracts and Provider Contracts.

2.10.16.1.2. DUE: Within five (5) Business Days of the Department's Request.

2.10.16.2. The Contractor shall notify the Department, in writing, of its decision to terminate any existing subcontractor at least sixty (60) calendar days prior to the services terminating, unless the basis for termination is for quality or performance issues, or credible allegation of fraud.

2.10.16.2.1. If the basis for termination is a quality or performance issue, the Contractor shall notify the Department in writing within two (2) Business Days of its decision to terminate the subcontract. The Contractor shall submit with the notice of termination, a narrative describing how it intends to provide or secure the services after termination.

2.10.16.2.1.1. DELIVERABLE: Notice of Subcontractor Termination.

2.10.16.2.1.2. DUE: At least sixty (60) calendar days prior to termination for all general terminations and within two (2) Business Days of the decision to terminate for quality or performance issue terminations.

2.10.16.3. The Contractor shall ensure that no Member is billed by a Subcontractor or Referral Provider for any amount greater than would be owed if the Contractor provided the services directly.

2.10.17. Warranties and certifications

2.10.17.1. The Contractor shall, within five (5) Business Days, disclose to the Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of this Contract.

2.10.17.1.1. DELIVERABLE: Warranty and Certification Notification.

2.10.17.1.2. DUE: Within five (5) Business Days of becoming aware of its inability to offer the warranty and certifications.

2.10.18. Anti-gag Requirements

2.10.18.1. The Contractor shall not prohibit or restrict a healthcare professional, acting within the lawful scope of practice, from advising or advocating on behalf of an Member who is his or her patient regarding:

2.10.18.1.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

2.10.18.1.2. Any information the Member needs in order to decide among all relevant treatment options.

2.10.18.1.3. The risks, benefits, and consequences of treatment or non-treatment.

2.10.18.1.4. The Member's healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.10.18.2. The Contractor shall not take any punitive action against a provider who either requests an expedited resolution or supports a member's appeal.

2.10.19. Moral and Religious Objections

2.10.19.1. The Contractor shall notify member's when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections.

2.10.19.2. If the Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the Contractor objects to the service on moral or religious grounds.

2.10.19.3. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it shall furnish information about the services it does not cover to the Department with its application for a Medicaid contract and whenever it adopts such a policy during the term of the contract.

2.10.19.4. If the Contractor does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information to Members on how and where to obtain such services, the Department shall provide that information to Members.

2.10.20. Provider-Preventable Conditions

2.10.20.1. The Contractor shall not make payments to Providers for provider-preventable conditions that:

2.10.20.1.1. Are identified in the State plan.

2.10.20.1.2. Have been found by the State, based on a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

2.10.20.1.3. Have a negative consequence for the Member.

2.10.20.1.4. Are auditable.

2.10.20.1.5. Include, at a minimum:

2.10.20.1.5.1. The wrong surgical or other invasive procedure performed on a patient.

2.10.20.1.5.2. A surgical or other invasive procedure performed on the wrong body part.

2.10.20.1.5.3. A surgical or other invasive procedure performed on the wrong patient.

2.10.20.2. The Contractor shall require all providers to report provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made.

2.10.20.3. The Contractor shall report all provider-preventable conditions to the Department.

2.10.20.3.1. DELIVERABLE: Provider-Preventable Conditions Report

2.10.20.3.2. DUE: Annually, within thirty (30) days following the end of the State Fiscal Year.

2.11. PROGRAM COMPLIANCE REPORTING

2.11.1.1. Access to Services Reports

2.11.1.1.1. The Contractor shall submit a quarterly report in electronic format to the Department and/or its designee, documenting the percentage of cases meeting standards for access to routine care, urgent care, and emergency care during the given quarter. The Contractor shall submit this report in a format approved by the Department.

2.11.1.1.2. The Contractor’s reports shall include detail regarding cases in which the standard was not met.

2.11.1.1.2.1. DELIVERABLE: Access to Services Report.

2.11.1.1.2.2. DUE: Thirty (30) days after the end of the reporting quarter.

2.11.1.2. 1915(b)(3) Waiver (Alternative) Services Report

2.11.1.2.1. The Contractor shall submit a quarterly report in electronic format, approved by the Department, to the Department and/or its designee detailing the previous quarter's expenditures for 1915(b)(3) Waiver (Alternative Services). Expenditure reports shall detail the specific types of services and the expenditure amounts associated with that service for the given quarter.

2.11.1.2.1.1. DELIVERABLE: 1915(b)(3) Waiver (Alternative) Services Report

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

2.11.1.2.2. Non-State Plan Services Expenditures Report

2.11.1.2.2.1. The Contractor shall submit a separate quarterly report in the same format to the Department and/or its designee detailing the previous quarter's expenditures for "Non-State Plan" services provided to MAGI Adults. In order to identify the population to be included in the report, the Department will submit a monthly file detailing the member ID and month of eligibility.

2.11.1.2.2.2. DELIVERABLE: Non-State Plan Services Expenditures Report

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

2.11.1.3. Annual Quality Report

2.11.1.3.1. The Contractor shall submit an annual report to the Department and/or its designee. The report shall include:

2.11.1.3.1.1. A description of the techniques used by the Contractor to improve its performance, effectiveness and quality outcomes. This report shall describe the qualitative and quantitative impact the techniques had on quality and the overall impact and effectiveness of the quality assessment and improvement program.

2.11.1.3.1.2. A description of past quality assessments and performance improvement activities targeted at creating substantial improvements in the quality and results for the next year.

2.11.1.3.1.3. A description and organizational chart for each quality committee.

2.11.1.3.1.4. Sufficient detail for the EQRO to validate the Contractor's performance improvement projects according to 42 C.F.R. Parts 433 and 438, External Quality Review of Medicaid Managed Care Organizations.

2.11.1.3.1.4.1. DELIVERABLE: Annual Quality Report

2.11.1.3.1.4.2. DUE: Annually by the last Business Day of September for the preceding fiscal year's quality activities.

2.11.1.4. Quality Improvement Plan

2.11.1.4.1. The Contractor shall submit an annual quality improvement plan to the Department and/or its designee, for approval, that delineates future quality assessment and performance improvement activities based on the results of those activities included in the Annual Quality Report.

2.11.1.4.2. The Contractor shall integrate findings and opportunities for improvement identified in studies, performance outcome measurements, Member satisfaction surveys and other monitoring and quality activities.

2.11.1.4.2.1. DELIVERABLE: Quality Improvement Plan.

2.11.1.4.2.2. DUE: Annually, no later than the last Business Day of September of each contract year.

2.11.1.5. Colorado Client Assessment Record (CCAR)

2.11.1.5.1. The Contractor shall submit CCAR data to the Division of Behavioral Health on a quarterly basis.

2.11.1.5.1.1. DELIVERABLE: Colorado Client Assessment Record (CCAR) Data.

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

2.11.1.6. Child Mental Health Treatment Act (CMHTA) Report

2.11.1.6.1. The Contractor shall submit to the Department an annual report of all children/youth authorized for placement in a residential treatment setting by the Contractor under the CMHTA.

2.11.1.6.1.1. DELIVERABLE: Child Mental Health Treatment Act (CMHTA) Report.

2.11.1.6.1.2. DUE: Annually on September 1st.

2.11.1.7. Member Grievance and Appeals Report

2.11.1.7.1. The Contractor shall submit a Grievance and Appeals report quarterly that records, tracks, and assesses Members' grievances and appeals and their resolutions.

2.11.1.7.2. The Contractor shall analyze, investigate and report upon significant individual cases and upon overall trends.

2.11.1.7.3. Upon request of the Department, Contractor shall also report upon individual cases.

2.11.1.7.3.1. DELIVERABLE: Member Grievance and Appeals Report.

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

2.11.1.8. Network Adequacy Report

2.11.1.8.1. The Contractor shall submit a quarterly Network Adequacy report. The report shall contain the total number of Providers by type of provider, county and the number of Providers who are accepting new Members.

2.11.1.8.1.1. DELIVERABLE: Quarterly Network Adequacy Report.

2.11.1.8.1.2. DUE: Thirty (30) days after the end of the reporting quarter.

2.11.1.8.2. Contractor shall annually conduct a needs assessment to identify unmet service needs in its service delivery area. The needs assessment shall be completed at least sixty (60) calendar days prior to the end of the contract year.

2.11.1.8.3. Thirty (30) calendar days prior to the end of the contract year, Contractor shall submit to the Department a copy of its need assessment report and shall provide written assurance that Contractor's Network is adequate in number, mix and geographic distribution and in accordance with Department standards, for the expected level of Membership in the Service Area for the following year.

2.11.1.8.3.1. DELIVERABLE: Need Assessment and Network Adequacy Report.

2.11.1.8.3.2. DUE: Thirty (30) calendar days prior to the end of the contract year.

2.11.1.8.4. If the needs assessment report indicates that the network is not adequate to meet the population of the Contractor's service area or if the Department determines that the network is not adequate, the Contractor shall submit an action plan outlining how and when the unmet needs will be addressed. Action plans are subject to Departmental review and approval.

2.11.1.8.4.1. DELIVERABLE: Adequacy Action Plan.

2.11.1.8.4.2. DUE: Thirty (30) calendar days prior to the end of the contract year.

2.11.1.8.5. The Contractor shall submit, within 30 days, a Network Composition Report when a new population is enrolled in Contractor's Plan, when new services are added to the contract, and/or when requested by the Department.

2.11.1.8.5.1. DELIVERABLE: Network Composition Report.

2.11.1.8.5.2. DUE: Within thirty (30) days of new enrollment or upon Department request.

2.11.1.9. Third Party Identification Report

2.11.1.9.1. Contractor shall submit a monthly report notifying the Department and the Department's fiscal agent of any third party payers, excluding Medicare, identified by the Contractor as being actually or potentially liable for some or all of the costs of Covered Services to Members.

2.11.1.9.2. For each Member identified as having other health insurance coverage, exclusive of Medicare, the report shall include:

2.11.1.9.2.1. Member's Medicaid identification number.

2.11.1.9.2.2. Member's social security number.

2.11.1.9.2.3. Member's relationship to policyholder.

2.11.1.9.2.4. Name, complete address, and telephone number of health insurer.

2.11.1.9.2.5. Policy Member identification and group numbers.

2.11.1.9.2.6. Policy Member's social security number.

2.11.1.9.2.7. Policy Member's full name, complete address and telephone number.

2.11.1.9.2.8. Daytime telephone number where the Member can be reached.

2.11.1.9.3. If the Contractor identifies a Member with Medicare, the report shall contain the Member's name and Medicaid identification along with the Medicare identification number.

2.11.1.9.4. If the Contractor identifies a Member with other forms of recovery potential (e.g. workers' compensation, motor vehicle accident insurance coverage, personal injury tort) the Contractor shall submit all known information regarding the circumstances giving rise to the recovery potential and the identification of the other parties and payers who may be liable.

2.11.1.9.4.1. DELIVERABLE: Third Party Identification Report.

2.11.1.9.4.2. DUE: Within ten (10) Business Days following the reporting month.

2.11.1.10. Compliance Program Plan

2.11.1.10.1. Contractor shall submit its Compliance Program Plan for approval upon each contract renewal.

2.11.1.10.1.1. DELIVERABLE: Compliance Program Plan.

2.11.1.10.1.2. DUE: Annually, no later than June 30th.

2.11.1.11. Compliance with False Claims Act

2.11.1.11.1. The Contractor shall submit its written policies that conform to the requirements detailed in Section 2.9.3., Program Integrity and detailing its compliance with:

2.11.1.11.1.1. The False Claims Act, 31 USC § 3729, et seq.

2.11.1.11.1.2. Administrative remedies for false claims and statements.

2.11.1.11.1.3. State laws relating to civil or criminal penalties for false claims and statements, if any.

2.11.1.11.1.4. Whistleblower protections under such laws.

2.11.1.11.1.4.1. DELIVERABLE: False Claims Policies.

2.11.1.11.1.4.2. DUE: Within forty-five (45) days after the Effective Date.

2.11.1.11.2. The Contractor shall submit, written assurance of compliance with the False Claims Act to the Department's Program Integrity Section.

2.11.1.11.2.1. DELIVERABLE: Assurance of Compliance.

2.11.1.11.2.2. DUE: Annually, within thirty (30) days of written notification by the Department's Program Integrity Section.

2.11.1.12. Graduate Medical Education Report

2.11.1.12.1. The Contractor shall submit a quarterly report detailing the total inpatient hospital days, total outpatient charges, and total inpatient discharges, by hospital, for Members for each calendar year quarter.

2.11.1.12.1.1. DELIVERABLE: Graduate Medical Education Report.

2.11.1.12.1.2. DUE: No later than ninety (90) calendar days following the end of the reporting quarter.

2.11.1.13. Performance Measures

2.11.1.13.1. The Contractor shall report annually on performance measures outlined in Exhibit F. Implementation of core performance measures shall begin upon implementation of this Contract.

2.11.1.13.2. Additional performance measures may be implemented and reported on in future contract years, by agreement between the Contractor and the Department.

2.11.1.13.2.1. DELIVERABLE: Performance Measures Report.

2.11.1.13.2.2. DUE: Annually as requested by the Department

2.11.1.14. Third Party Recovery Report

2.11.1.14.1. The Contractor shall submit an annual report of all amounts actually recovered from third parties. The report shall contain the Medicaid Member ID, category of assistance and dates of service related to the recovery. The report shall be provided on compact disc or by encrypted email.

2.11.1.14.1.1. DELIVERABLE: Third Party Recovery Report.

2.11.1.14.1.2. DUE: Annually, no later than March 31st for the preceding fiscal year.

2.11.1.15. Annual Training Report

2.11.1.15.1. At the end of each calendar year, the Contractor shall create an Annual Training Report detailing trainings that were provided by the Contractor to its Providers, state agencies, and counties during the previous calendar year.

2.11.1.15.2. This report shall be in a format mutually agreed upon by the Department and the Contractor. This report shall detail trainings related to the requirements, policies, and procedures related to this Contract, including but not limited to, access to care, care coordination, services available to members, member transitions, the Child Mental Health Treatment Act (CMHTA), member rights (appeals and grievances).

2.11.1.15.2.1. DELIVERABLE: Annual Training Report.

2.11.1.15.2.2. DUE: Annually on January 30th.

2.11.1.16. Integrated Care Report

2.11.1.16.1. The Contractor shall collaborate with the RCCO in its region on a semi-annual report regarding integrated care efforts in its region. The Department shall provide a standardized template for this report. The report is due from the RCCO thirty (30) calendar days following each reporting period.

2.11.1.17. Health Insurance Providers Fee Reporting

2.11.1.17.1. In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 CFR Part 57 and required to file a form 8963, then the Contractor shall create a Health Insurance Providers Fee Report to the Department that contains all of the following information:

2.11.1.17.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).

2.11.1.17.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was $0.00.

2.11.1.17.1.3. An allocation of the fee attributable to the Work under this Contract.

2.11.1.17.1.4. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.

2.11.1.17.2. The Contractor shall deliver the Health Insurance Providers Fee Report for each year that it is required to file a form 8963 with the IRS.

2.11.1.17.2.1. DELIVERABLE: Health Insurance Providers Fee Report

2.11.1.17.2.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963

2.11.1.18. Ad Hoc Compliance Reports

2.11.1.18.1. Upon request of the Department, the Contractor shall create ad hoc reports for compliance purposes. The Contractor may also be asked to collaborate with other State contractors (e.g. RCCOs) on reporting deliverables.

2.11.1.18.1.1. DELIVERABLE: Ad Hoc Compliance Reports.

2.11.1.18.1.2. DUE: Within fifteen (15) days of the Department's request.

2.11.1.19. Health Insurance Providers Fee Rate Settlement

2.11.1.19.1. The Contractor and the Department shall engage in Health Insurance Providers Fee Rate Settlements based upon the Health Insurance Providers Fee report provided by the Contractor to the Department each October. Each Health Insurance Providers Fee Rate Settlement process shall include the following:

2.11.1.19.1.1. During the rate-setting cycle, the Department will calculate a prospective rate to account for the health insurance provider fee. This rate will be withheld from the Contractor's payment.

2.11.1.19.1.2. Upon receipt of the Health Insurance Providers Fee Report, the Department will calculate the actual rate to account for the health insurance provider fee. The Department will issue a notification letter by July 31st with the amount to be remitted to the Contractor. The Department will calculate the actual rate to account for the health insurer provider fee and will update the amount withheld for the health insurer provider fee through a contract amendment.

2.11.2. Institutional Compliance Reporting

2.11.2.1. Insurance Report

2.11.2.1.1. The Contractor shall submit documentation upon request by the Department establishing current and continuous insurance coverage.

2.11.2.1.2. The Department reserves the right to require complete, certified copies of all insurance policies required by this Agreement at any time.

2.11.2.1.2.1. DELIVERABLE: Insurance Report.

2.11.2.1.2.2. DUE: Within five (5) Business Days of request by the Department.

2.11.2.1.3. The Contractor shall submit to the Department financial reports for the previous fiscal year, produced in accordance with the Mental Health Accounting and Auditing Guidelines, and audited by an independent Certified Public Accountant.

2.11.2.1.3.1. DELIVERABLE: Financial Report.

2.11.2.1.3.2. DUE: Annually, no later than April 1st.

2.11.2.2. Personnel and Committee Report

2.11.2.2.1. The Contractor shall submit a report at the request of the Department identifying the following individuals:

2.11.2.2.1.1. Privacy Officer

2.11.2.2.1.2. Security Officer

2.11.2.2.1.3. Compliance Officer

2.11.2.2.1.4. QI Committee Members

2.11.2.2.1.5. Credentialing Committee Members

2.11.2.2.2. At the request of the Department the Contractor shall also submit the training, education and credentials of these individuals.

2.11.2.2.2.1. DELIVERABLE: Personnel and Committee Report.

2.11.2.2.2.2. DUE: Within five (5) days of request by the Department

2.11.2.3. Security Events Report

2.11.2.3.1. The Contractor shall submit, quarterly, a report focusing on the following four (4) primary potential risk areas:

2.11.2.3.1.1. Unauthorized systems access.

2.11.2.3.1.2. Compromised data.

2.11.2.3.1.3. Loss of data integrity.

2.11.2.3.1.4. Inability to transmit or process data.

2.11.2.3.2. Upon discovery, the Contractor shall disclose any and all incidents falling into the categories listed above, shall document its internal review of these incidents, and shall provide to the Department its corrective actions and other mitigating measures.

2.11.2.3.2.1. DELIVERABLE: Security Events Report

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

2.11.2.4. General

2.11.2.4.1. The Contractor shall inform the Department, within five (5) Business Days, of any significant event or change in circumstances that might beneficially or adversely affect Members, Providers, the Department or other stakeholders.

2.11.2.4.1.1. DUE: Significant Event/Circumstance Report.

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

2.12. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

2.12.1. In accordance with 42 U.S.C. 1396a(a)(68), the Contractor shall establish written policies, for all employees (including management) and for any contractor or agent, that include detained information about the False Claims Act, 31 USC § 3729, et seq., administrative remedies for false claims and statements established under chapter 38 or title 31, United States Code, the Colorado Medicaid False Claims Act, Section 25.5-4-304 C.R.S. et seq., detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse, whistleblower protections and the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs.

2.12.2. The Contractor shall provide upon request by the Department written assurances and submit its written policies and procedures. The written assurances are:

2.12.2.1. The Contractor has the policy and procedures required by 42 U.S.C. 1396a(a)(68).

2.12.2.2. The Contractor has incorporated language required by statute into the employee handbook, if one exists.

2.12.2.3. The policy and procedures have been disseminated to all employees including management and employees of any contractor or agent.

2.12.2.4. The Contractor understands that failure to comply within thirty (30) calendar days from the date of the request by the Department for assurances and submissions may result in suspension or termination.

2.12.2.4.1. DELIVERABLE: Written assurances, policies and procedures and employee handbook, if one exists.

2.12.2.4.2. DUE: Annually, within thirty (30) days of the date of written request by the Department's Program Integrity Section.

SECTION 3.0 CONTRACTOR'S GENERAL REQUIREMENTS

3.1. GENERAL REQUIREMENTS

3.1.1. The Contractor may be privy to internal policy discussions, contractual issues, price negotiations, confidential medical information, Department financial information, and advance knowledge of legislation. In addition to all other confidentiality requirements of the Contract, the Contractor shall also consider and treat any such information as confidential and shall not disclose it to any third party without the written consent of the Department.

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

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

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

3.1.5. Subcontractual Relationships and Delegation

3.1.5.1. The Contractor shall be accountable for any functions and responsibilities that it delegates to any subcontractor. The Contractor shall:

3.1.5.1.1. Evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

3.1.5.1.2. Require a written agreement with the Subcontractor that specifies the activities and report responsibilities delegated to the Subcontractor; and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

3.1.5.1.3. Monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

3.1.5.1.4. Identify deficiencies or areas for improvement, and shall ensure that the Subcontractor takes corrective action.

3.2. KEY PERSONNEL REQUIREMENTS

3.2.1. The Contractor shall designate people to hold the Key Personnel positions as specified in this Contract. The Contractor shall not allow for any individual to fill more than one of the roles defined as Key Personnel unless the Department has granted approval. Key personnel (unless otherwise stated) must be primarily located or stationed in Colorado for the duration of this Contract.

3.2.2. The Contractor shall ensure Key Personnel and other personnel assigned to the Contract are available for meetings with the Department during the Department's normal Business Hours. The Contractor shall also make these personnel available outside of the Department's normal Business Hours and on weekends with prior notice from the Department.

3.2.3. The Contractor's Key Personnel and other operational staff shall be available for all regularly scheduled meetings between the Contractor and the Department, unless the Department has granted prior, written approval otherwise.

3.2.4. The Contractor shall ensure that the personnel and staff attending all meetings between the Department and the Contractor have the authority to represent and commit the Contractor regarding work planning, problem resolution and program development.

3.2.5. At the Department's direction, the Contractor shall make its Key Personnel and other personnel assigned to the Contract available to attend meetings as subject matter experts with stakeholders both within the State government and external or private stakeholders.

3.2.6. All of the Contractor's personnel that attend any meeting with the Department or other Department stakeholders shall be physically present at the location of the meeting, unless the Department gives prior, written permission to attend by telephone or video conference.

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

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

3.2.9. The Contractor shall supply the Department with the name(s), resume and references for any proposed replacement whenever there is a change to Key Personnel. Any individual replacing Key Personnel shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department.

3.2.9.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change

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

3.2.10. The Key Personnel identified for this Contract are:

3.2.10.1. Executive Director or Chief Executive Officer

3.2.10.2. Chief Financial Officer

3.2.10.3. Chief Medical Director/Officer

3.2.10.4. Clinical Substance Use Disorder Coordinator. The Clinical Substance Use Disorder Coordinator shall:

3.2.10.4.1. Be knowledgeable regarding Substance Use Disorder diagnoses, services, supports, and treatments.

3.2.10.4.2. Be knowledgeable on providing care coordination and recovery approaches for Substance Use Disorder Members.

3.2.10.5. Director of Utilization Management

3.2.10.6. Member and Family Affairs Director

3.2.10.7. Outcomes or Quality Improvement Director

3.3. OTHER PERSONNEL REQUIREMENTS

3.3.1.1. The Contractor shall provide Other Personnel, individuals in addition to Key Personnel, to ensure Contractor's ability to complete the Work (Subcontractors or providers in the Contractor's network are not included in this category).

3.3.1.2. Contractor shall use its discretion to determine all Other Personnel it will require to complete the Work.

3.3.1.3. The Contractor shall ensure that the Other Personnel have previous experience, education and/or training that demonstrate that they are qualified for the positions on this project to which they will be assigned.

3.3.2. Subcontractors

3.3.2.1. The Contractor may subcontract to complete a portion of the Work required by the Contract. The conditions for using a Subcontractor or Subcontractors are as follows:

3.3.2.1.1. The Contractor shall not subcontract more than forty percent (40%) of the Work. Providers in the Contractor's network providing behavioral health services to Members are not considered Subcontractors.

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

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

3.3.2.1.2.2. DUE: The later of thirty (30) days prior to the Subcontractor beginning work or the Effective Date.

3.3.2.2. The Contractor shall obtain prior consent and written approval for any change in the use of Subcontractor(s).

3.4. DELIVERABLES

3.4.1. All deliverables shall meet Department-approved format and content requirements. The Department will specify the number of copies and media for each deliverable. The Contractor shall make all changes to deliverables as directed by the Department.

3.4.2. Each deliverable will follow the deliverable submission process as follows:

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

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

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

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

3.4.2.3. Once the Department has received an acceptable version of the deliverable, including all changes directed by the Department, the Department will notify the Contractor of its acceptance of the deliverable. A deliverable shall not be deemed accepted prior to the Department's notice to the Contractor of its acceptance of that deliverable.

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

3.4.4. At the Department's request, the Contractor shall be required to conduct a walk-through of Department-selected deliverables to facilitate the Department's review process. The walk-through shall consist of an overview of the deliverable, explanation of the organization of the deliverable, presentation of critical issues related to the deliverable and other information as requested by the Department. It is anticipated that the content of the walk-through may vary with the deliverable presented.

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

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

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

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

3.4.8.1. Any deliverable described as an update of another deliverable shall be considered a version of the original deliverable for the purposes of this subsection.

3.4.9. Any document, report, deliverable or other item delivered to the Department for review and approval shall require written approval by the Department before the Contractor may consider that document, report, deliverable or other item approved and complete. Written approval by the Department may be delivered via electronic mail (email) to the Contractor.

3.5. STATED DELIVERABLES AND PERFORMANCE STANDARDS

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

3.6. COMMUNICATION REQUIREMENTS

3.6.1. Communication with the Department

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

3.6.2. Communication with Members, Providers and Other Entities

3.6.2.1. The Contractor shall create a Communication Plan that includes, but is not limited to, all of the following:

3.6.2.1.1. A description of how the Contractor will communicate to Members any changes to the services those Members will receive or how those Members will receive the services.

3.6.2.1.2. A description of the communication methods, including things such as email lists, newsletters and other methods, the Contractor will use to communicate with Providers and Subcontractors.

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

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

3.6.2.1.5. A listing of the following individuals within the Contractor's organization, that includes cell phone numbers and email addresses:

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

3.6.2.1.5.2. An individual who is responsible for any website or marketing related to the Work.

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

3.6.2.2. The Contractor shall deliver the Communication Plan to the Department on a template provided by the Department or Contractor. The template is subject to approval by the Department.

3.6.2.2.1. DELIVERABLE: Communication Plan

3.6.2.2.2. DUE: Within sixty (60) Business Days after the Effective Date or longer if approved by the Department.

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

3.6.2.3.1. DELIVERABLE: Annual Communication Plan Update

3.6.2.3.2. DUE: Annually, by June 30th of each year

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

3.6.2.4.1. DELIVERABLE: Interim Communication Plan Update

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

3.6.3. Marketing

3.6.3.1. The Contractor shall not distribute marketing materials without first obtaining Department approval.

3.6.3.1.1. All marketing, plans and materials, must be accurate and not misleading, confusing, or defrauding the recipients or the Department.

3.6.3.1.2. Marketing materials shall not contain any assertion or statement (whether written or oral) that the recipient must enroll with a MCE in order to obtain benefits or in order to not lose benefits.

3.6.3.1.3. The Contractor shall ensure that its marketing materials do not contain any assertion or statement (whether written or oral) that CMS, the Federal or State government, or similar entity endorses the Contractor.

3.6.3.2. The Contractor shall distribute marketing materials to its entire service area as defined by this contract.

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

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

3.7. BUSINESS CONTINUITY

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

3.7.1.1. How the Contractor will replace staff that has been lost or is unavailable during or after a Business Interruption or disaster so that the Work is performed in accordance with the Contract.

3.7.1.2. How the Contractor will back-up all information necessary to continue performing the Work, so that no information is lost because of a Business Interruption or disaster.

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

3.7.1.3. How the Contractor will minimize the effects on Members in the event of a Business Interruption or disaster.

3.7.1.4. How the Contractor will communicate with the Department during the Business Interruption or disaster and points of contact within the Contractor's organization the Department can contact in the event of a Business Interruption or disaster.

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

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

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

3.7.2.1. DELIVERABLE: Business Continuity Plan.

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

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

3.7.3.1. DELIVERABLE: Updated Business Continuity Plan

3.7.3.2. DUE: Semi-annually, by June 30th and December 31st of each year

3.7.4. In the event of any Business Interruption, the Contractor shall implement its most recently approved Business Continuity Plan or Updated Business Continuity Plan immediately after the Contractor becomes aware of the Business Interruption. In that event, the Contractor shall comply with all requirements, deliverables and milestones contained in the implemented plan.

3.8. FEDERAL FINANCIAL PARTICIPATION RELATED INTELLECTUAL PROPERTY OWNERSHIP

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

3.8.2. To facilitate obtaining the desired amount of federal financial participation under 42 CFR §433.112, the Department shall have all ownership rights, not superseded by other licensing restrictions, in all materials, programs, procedures, designed, purchased, or developed by the Contractor and primarily funded by the Department specifically and solely to perform the Work. "Primarily funded" in this context shall mean fifty-one percent (51%) or more of the funding to design, purchase or develop such materials, programs or procedures. Proprietary materials, programs, procedures, etc., that were not designed, purchased, or developed by the Contractor specifically and solely to perform the Work, and not primarily funded by the Department specifically and solely to perform the Work, even if used to perform the Work, remain the property of the Contractor. The Contractor shall use contract funds to develop all necessary materials, programs, products, procedures, etc., and data and software to specifically fulfill its obligations under the Contract. Department funding used in the development of these materials, programs, procedures, etc. specifically and solely to perform the Work shall be documented by the Contractor. The Department shall have all ownership rights in data and software, or modifications thereof and associated documentation and procedures specifically and solely designed and developed to produce any systems, programs reports and documentation and all other work products or documents created under the Contract. Data and software, or modifications thereof and associated documentations and procedures which are used by the Contractor for multiple lines of business and/or which are created for commercial purposes, and are also used to support the Work, shall not be subject to the Department's ownership rights. The Department reserves, on behalf of itself, the Federal Department of Health and Human Services and its Contractors, a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures that were specifically and solely designed, purchased or developed to perform the Work.

3.9. PERFORMANCE REVIEWS

3.9.1. The Department or its designee may conduct performance reviews or evaluations of the Contractor in relation to the Work performed under the Contract.

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

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

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

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

3.10. CORRECTIVE ACTION PLANS

3.10.1. Upon request by the Department, the Contractor shall investigate any contract compliance concerns. The Contractor shall submit a written response to the Department that includes a brief description of the issue, the efforts that Contractor took to investigate the issue, the outcome of the Contractor's review.

3.10.1.1. The written response shall be sent to the Department within thirty (30) calendar days of the Department's request. Upon request, the Department may allow additional time to investigate and report.

3.10.1.1.1. DELIVERABLE: Compliance Concerns Response.

3.10.1.1.2. DUE: Within thirty (30) calendar days of the Department's request.

3.10.2. When the Department determines that Contractor is not in compliance with any term of this Contract, Contractor, upon written notification by the Department, shall develop a corrective action plan. Contractor shall prepare a Corrective Action Plan within thirty (30) calendar days of the receipt of a written request.

3.10.2.1. The Contractor shall notify the Department in writing, before the due date if it will not be able to present the corrective action plan within the thirty (30) days. The Contractor shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Contractor's compliance.

3.10.2.2. DELIVERABLE: Corrective Action Plan

3.10.2.3. DUE: Within thirty (30) days of receipt of a written request from the Department.

3.10.3. Upon receipt of the Contractor's corrective action plan, the Department shall accept, modify or reject the proposed corrective action plan. Modifications and rejects shall be accompanied by a written explanation.

3.10.3.1. In the event of a rejection of Contractor's corrective action plan the Contractor shall re-write the corrective action plan and resubmit it to the Department for review.

3.10.3.1.1. DELIVERABLE: Revised Corrective Action Plan.

3.10.3.1.2. DUE: Within fifteen (15) days of the Department's rejection.

3.10.4. Upon acceptance by the Department the Contractor shall implement the corrective action plan.

3.10.5. Contractor shall cooperate with any Department follow-up reviews or audits at any time after the initiation of the corrective action plan.

3.10.6. Corrective action plans shall include, but not be limited to:

3.10.6.1. A detailed time frame specifying the actions to be taken,

3.10.6.2. Contractor's employee(s) responsible for implementing the actions,

3.10.6.3. The implementation time frames and a date for completion.

3.10.7. Department staff shall monitor progress on the corrective action plan until the Contractor is found to be in compliance.

3.10.7.1. Department staff will notify Contractor in writing when the corrective actions have been completed, accepted and the Contractor is considered to be in compliance with Department regulations and this Contract.

3.10.8. If the Contractor notifies the Department that it will not be able to achieve compliance by the date specified in the Corrective Action Plan, and explains in writing its reasonable efforts to achieve compliance, the Department may grant an extension of the deadline, in writing, for Contractor compliance.

3.10.9. The Department reserves the right to reduce the time frame for a corrective action if delivery of Covered Services for Members is adversely affected.

3.10.10. If at the end of the specified time period, the Contractor has not demonstrated compliance, as determined by the Department, the Department may exercise any available remedy under this Contract.

3.10.11. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during corrective action periods.

3.11. RENEWAL OPTIONS

3.11.1. The Department may, within its sole discretion, choose to not exercise any renewal option in the Contract for any reason. If the Department chooses to not exercise an option, it may reprocure the performance of the Work in its sole discretion.

SECTION 4.0 START-UP AND CLOSEOUT PERIODS

4.1.1. The Contract shall have a Start-Up Period and a Closeout Period.

4.1.1.1. The Start-Up Period shall begin on the Effective Date. The Start-Up Period shall end on the Operational Start Date of the Contract.

4.1.1.1.1. The Operational Start Date shall not occur until the Contractor has completed all requirements of the Start-Up Period.

4.1.1.1.2. The Contractor shall not engage in any Work under the Contract, other than the Work described below in the Start-Up Period, prior to the Operational Start Date. The Department shall not be liable to the Contractor for, and the Contractor shall not receive, any payment for any period prior to the Operational Start Date under the Contract.

4.1.1.2. The Closeout Period shall begin on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice of by the Department of non-renewal. The Closeout Period shall end on the day that the Department has accepted the final deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

4.1.1.2.1. This Closeout Period may extend past the termination of the Contract and the requirements of the Closeout Period shall survive termination of the Contract.

4.1.2. Start-Up Period

4.1.2.1. During the Start-Up Period, the Contractor shall complete all of the following:

4.1.2.1.1. Create a Policy and Procedures Manual that contains the policies and procedures for all systems and functions necessary for the Contractor to complete its obligations under the Contract.

4.1.2.1.1.1. DELIVERABLE: Policies and Procedure Manual

4.1.2.1.1.2. DUE: The later of five (5) days prior to the Operational Start Date, or the Effective Date unless more time is allowed and approved by the Department.

4.1.2.1.2. Prepare all documents, forms, training materials, and any other documents, information and protocols that require approval by the Department. The Contractor shall deliver all documents, forms, training materials, and any other documents, information and protocols that require approval by the Department to the Department for review and approval in a timely manner that allows the Department to review and approve those documents prior to end of the Start-Up Period.

4.1.2.1.3. Create and implement the Business Continuity Plan described in Section 3.7.

4.1.2.1.4. Create and implement the Communication Plan described in Section 3.6.

4.1.2.2. The Contractor shall provide bi-weekly updates, to the Department, throughout the Start-Up Period, that show the Contractor's status toward meeting the timelines and milestones described in the Contract.

4.1.2.3. The Contractor shall ensure that all requirements of the Start-Up Period are complete by the deadlines contained in the Contract and that the Contractor is operationally ready by the Operational Start Date.

4.1.3. Closeout Period

4.1.3.1. During the Closeout Period, the Contractor shall complete all of the following:

4.1.3.1.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

4.1.3.1.2. Complete all steps, deliverables and milestones contained in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

4.1.3.1.3. Provide to the Department, or any other contractor at the Department's direction, all reports, data, systems, deliverables and other information reasonably necessary for a transition as determined by the Department or included in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

4.1.3.1.4. Ensure that all responsibilities under the Contract have been transferred to the Department, or to another contractor at the Department's direction, without significant interruption.

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

4.1.3.1.6. Notify all Members that the Contractor will no longer be their assigned Behavioral Health Organization. The Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, the Contractor shall deliver these notifications to all Members, but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

4.1.3.1.6.1. DELIVERABLE: Member Notifications

4.1.3.1.6.2. DUE: Thirty (30) days prior to termination of the Contract

4.1.3.1.7. Continue meeting each requirement of the Contract as described in the Department-approved and updated Closeout Plan, or until the Department determines that specific requirement is being performed by the Department or another contractor, whichever is sooner. The Department will determine when any specific requirement is being performed by the Department or another contractor, and will notify the Contractor of this determination for that requirement.

4.1.3.2. The Department will perform a closeout review to ensure that the Contractor has completed all requirements of the Closeout Period. The Contractor shall ensure that all responsibilities of the Closeout Period will be complete by the termination of the Contract. In the event that the Contractor has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract.

4.1.4. Closeout Planning

4.1.4.1. Closeout Plan

4.1.4.1.1. The Contractor shall create a Closeout Plan that describes all steps, timelines and milestones necessary to fully transition the services described in the Contract from the Contractor to the Department to another contractor selected by the Department after termination of the Contract. The Closeout Plan shall also designate an individual to act as a transition coordinator, who will ensure that all steps, timelines and milestones contained in the Closeout Plan are completed and work with the Department and any other contractor to minimize the impact of the transition on Member and the Department. The Contractor shall deliver the Closeout Plan to the Department for review and approval.

4.1.4.1.1.1. DELIVERABLE: Closeout Plan

4.1.4.1.1.2. DUE: Thirty (30) days following the Effective Date

4.1.4.1.2. The Contractor shall update the Closeout Plan, at least annually, to include any technical, procedural or other changes that impact any steps, timelines or milestones contained in the Closeout Plan, and deliver this Closeout Plan Update to the Department for review and approval.

4.1.4.1.2.1. DELIVERABLE: Closeout Plan Update

4.1.4.1.2.2. DUE: Annually, by June 30th of each year.

SECTION 5.0 COMPENSATION

5.1. COMPENSATION

5.1.1. The Department shall remit to the Contractor, on behalf of each Member who is eligible for Covered Services, the appropriate Monthly Capitation Rate for each full month for which each Member is eligible for Covered Services, as specified by Exhibit B, on approximately the fifteenth (15th) Business Day of the month.

5.1.2. The Monthly Capitation Rate, as specified by Exhibit B, falls within the rate range that is certified by a qualified actuary.

5.1.2.1. The Department retains the discretion to select a payment rate within the actuarially sound rate range based on the performance and timeliness of contract deliverables and in coordination with the Contractors.

5.1.3. The Department shall remit to the Contractor a prorated Monthly Capitation Rate for any Member whose enrollment begins after the first (1st) of the month, including Members retroactively enrolled, based on the Rates as specified in Exhibit B.

5.1.3.1. The prorated Monthly Capitation Rate is calculated by the MMIS. The MMIS converts the Monthly Capitation Rate into a per diem rate by dividing the Monthly Capitation Rate by the number of days in the month. The Contractor is reimbursed by the MMIS for the number of days that the Member is enrolled during the month.

5.1.3.2. To calculate the Monthly Capitation Rate and corresponding rate ranges, the Department converts the capitations paid to the Contractor into member months. The member months are calculated in the same manner described above to reflect the prorated capitation payments during the contract period.

5.1.3.3. The Department will remove the amount submitted in the annual Third Party Recovery Report, described in Section 2.11.1.1, from the calculation of the Monthly Capitation Rates. The Department will not seek recovery of reimbursement from the Contractor.

5.1.4. Payment for retroactive eligibility months shall be made in the month following the date of the eligibility determination. The payment amount is calculated based on the capitation rates and the number of retroactive enrollment months, which is limited to three (3) months prior to the date that Medicaid eligibility is determined. When a material underpayment error in the amount of the Monthly Capitation Rate has been made due to an error by the Department, the Department shall remit to the Contractor the amount necessary to correct the error within ten (10) Business Days of notification of the error by the Contractor to the Department.

5.1.5. Where membership is disputed between two Contractors, the Department shall be the final arbiter of membership and shall recoup any Monthly Capitation Rate amounts paid in error.

5.1.6. In addition to the Financial Reporting, outlined in Section 2.9.10.8, per 42 CFR 438.6(g) the Contractor shall allow the Department to inspect and audit the financial records of the Contractor and its Subcontractors related to this Contract.

5.1.7. The Department shall not make any payments to a provider other than the Contractor for services available under the Contract, except when these payments are specifically provided for in title XIX of the Social Security Act, in 42 C.F.R., or when the Department has adjusted the capitation rates paid under the contract, in accordance with §438.6I(5)(v) to make payments for graduate medical education.

5.2. RECONCILIATION

5.2.1. The Contractor shall be subject to the following reconciliation process:

5.2.1.1. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) calendar days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) calendar days, the Department shall deduct the overpayments from the next payment to the Contractor.

5.3. EXPANSION POPULATION RATE SETTLEMENTS

5.3.1. The Contractor and the Department shall engage in Expansion Rate Settlements for future calendar years based upon the risk corridor presented in Exhibit B. Each Expansion Parent and MAGI Adult Rate Settlement process shall include the following:

5.3.1.1. The Contractor shall send Expansion encounter data, together with the monthly mental health encounter submissions, to the Department in a monthly flat-file format and in the ANSI ASC X12N 837 format, as outlined in Section 2.9.4.

5.3.1.2. The Department will identify Expansion Clients by the capitation file.

5.3.1.3. The Department will price the Expansion Clients encounter data and will calculate the actual Expansion Parent and MAGI Adult PMPMs. The actual PMPMs will be compared to the paid Behavioral Health Rate without administrative load.

5.3.1.4. The Department will calculate settlements according to the terms in the risk corridor presented in Exhibit B by March 31, 2018.

5.3.1.5. The Department, upon completion of the thirty (30) day review period, will issue a demand letter with the settlement amount that shall be either remitted to the Contractor or recouped from the Contractor, by June 30, 2018.

5.4. MEDICAL LOSS RATIO (MLR) SETTLEMENTS

5.4.1. The Contractor shall maintain a MLR in excess of seventy seven percent (77%) of total Medicaid capitations. MLRs of less than seventy seven percent (77%) shall result in a refund due the Department if the amount of the medical loss is less than the threshold.

5.4.1.1. The Department will calculate the MLR for the Contractor using the audited financial reports, as required in Section 2.11.2.1.3., no later than June 30th.

5.4.1.2. If the Contractor's MLR is less than seventy seven percent (77%) of the total Medicaid capitations, the Department will issue a demand letter with the settlement amount that the Contractor shall reimburse the Department.

5.5. HEALTH INSURANCE PROVIDER FEE REPORTING

5.5.1. In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 CFR Part 57 and required to file a form 8963, then the Contractor shall create a Health Insurance Providers Fee Report that contains all of the following information:

5.5.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).

5.5.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was $0.00.

5.5.1.3. An allocation of the fee attributable to the Work under this Contract.

5.5.1.4. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.

5.5.2. The Contractor shall deliver the Health Insurance Providers Fee Report for each year that it is required to file a form 8963 with the IRS.

5.5.2.1. DELIVERABLE: Health Insurance Providers Fee Report.

5.5.2.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963.

5.6. THIRD PARTY LIABILITY

5.6.1. Establishment of Third Party Liability

5.6.1.1. If the Contractor has established the probable existence of third party liability at the time the claim is filed, the Contractor must reject the claim and return it to the provider for a determination of the amount of liability.

5.6.1.1.1. The establishment of third party liability occurs when the Contractor receives confirmation from the provider or a third party resource indicating the extent of third party liability.

5.6.1.1.2. When the amount of liability is determined, the Contractor must then pay the claim to the extent that payment allowed under the Contractor's payment schedule exceeds the amount of the third party's payment.

5.6.1.2. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the Contractor must pay the full amount allowed under the Contractor's payment schedule.

5.6.2. Recovery of Third Party Liability

5.6.2.1. If third party liability is discovered, the Contractor shall recover reimbursement.

5.6.2.1.1. If the Contractor learns of the existence of third party liability after a claim is paid, or benefits become available from a third party after a claim is paid, the Contractor shall seek recovery of reimbursement within sixty (60) days after the end of the month in which it learns of the existence of third party liability or benefits become available.

EXHIBIT B-5, RATES AND HIPF RATE SETTLEMENT

RATES
Effective July 1, 2016 – June 30, 2017

The Contractor shall earn the following Full Risk Rates shown in the following table:

	Behavioral Health Rate
Elderly	$17.45
Disabled	$142.11
Non-Expansion Adult	$33.94
Expansion Parent	$20.11
Children	$26.59
Foster Care	$131.89
MAGI Adult	$55.08

The Department shall withhold an amount from the Full Risk Rates to account for the health insurance provider fee as shown in the following table:

	Behavioral Health Rate
Elderly	$0.38
Disabled	$3.06
Non-Expansion Adult	$0.73
Expansion Parent	$0.43
Children	$0.57
Foster Care	$2.84
MAGI Adult	$1.19

Once the Department has withheld the amount listed in the above table, the Contractor shall receive the amount shown in the following table:

	Behavioral Health Rate
Elderly	$17.07
Disabled	$139.05
Non-Expansion Adult	$33.21
Expansion Parent	$19.68
Children	$26.02
Foster Care	$129.05
MAGI Adult	$53.89

The Contractor and the Department shall engage in Health Insurance Providers Fee Rate Settlements based upon the Health Insurance Providers Fee report provided by the Contractor to

the Department each October. Each Health Insurance Providers Fee Rate Settlement process shall include the following:

Upon receipt of the Health Insurance Providers Fee Report, the Department will calculate the actual rate to account for the health insurance provider fee. The Department will issue a notification letter by July 31st with the amount to be remitted to the Contractor.

The Department will pay the Contractor all amounts withheld during the year up to the actual rate calculated by the Department to account for the health insurance provider fee.

The Contractor shall assume risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract, with the exception of the expansion population, where there is a risk corridor. For all other populations, the entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions, including incentive payments, are medical assistance costs.

HIPF RATE SETTLEMENT
Rates Effective July 1, 2015 – December 31, 2015

The Contractor and the Department engaged in Health Insurance Providers Fee Rate Settlements when the Department received the Health Insurance Providers Fee report provided by the Contractor. This resulted in a final withhold amount as shown in the following table.

	Behavioral Health Rate
Elderly	$0.47
Disabled	$3.28
Non-Expansion Parent	$0.72
Expansion Parent	$0.48
Children	$0.61
Foster Care	$4.61
MAGI Adult	$1.83

EXHIBIT D-2, COVERED BEHAVIORAL HEALTH DIAGNOSES

Part I- Mental Health Covered Diagnosis Ranges

Start Value	End Value
F20.0	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F60.0	F63.9
F68.10	F69
F90.0	F99
R45.1	R45.2
R45.5	R45.82

Part II- Substance Use Disorder Covered Diagnosis Ranges

Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

Part III – Other Diagnoses

R69
Z03.89

EXHIBIT G-1, PERFORMANCE MEASURES

Heading	Description	Source	Notes
Indicator 1	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	NQF 1365 Awaiting further specifications from CMS/SAMHSA	The Contractor shall work with each of their network CMHCs and providers that serve 1000 or more unique members annually to develop a plan for collecting data for this measure during this Contract period.
Indicator 2	Adult major depressive disorder (MDD): Suicide risk assessment.	NQF 0104 Awaiting further specifications from CMS/SAMHSA	The Contractor shall work with each of their network CMHCs and providers that serve 1000 or more unique members annually to develop a plan for collecting data for this measure during this Contract period.
Indicator 3	a) Hospital Readmissions: 7,30 & 90 days b) Hospital Readmissions: 180 days	1768/SIM	Will review existing scope document to align with SIM methodology as closely as possible.
Indicator 4	Percent of Members prescribed redundant or duplicated atypical antipsychotic medication	Department Defined	
Indicator 5	Adherence to antipsychotics for individuals with schizophrenia	CMS Core - NQF 1879	
Indicator 6	ECHO Survey	Department Defined	
Indicator 7	Penetration Rates	Department Defined	
Indicator 8	Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication	1932 NQF	
Indicator 9	Inpatient Utilization	Department Defined	Will review existing scope document to align with SIM methodology as closely as possible.
Indicator 10	Emergency Department Utilization for mental health condition	Department Defined	Will review existing scope document to align with SIM

			methodology as closely as possible.
Indicator 11	Follow up after discharge from the ED for Mental Health or Alcohol or Drug Dependence	2605 NQF	Will align with SIM whenever possible.
Base Measures- These performance measures will be considered in the rate setting process.			
Indicator 12	Mental Health Engagement	Department Defined	Will review existing scope document methodology.
Indicator 13	a) Initiation of Alcohol and Other Drug Dependence Treatment b) Engagement of Alcohol and Other Drug Dependence Treatment	0004 CMS - excludes inpatient.	Will review existing scope document.
Indicator 14	Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition- Adult and Child/Adolescent	CMS Core 0576	Will review existing scope document to align with SIM methodology as closely as possible.
Stretch Measures – Each BHO must choose at least one of the stretch measures below to participate in the Performance Incentive Program referenced in Section 2.8.6. of the Contract. These measures/projects will be implemented at large provider sites such as CMHCs. Targets for components of measure implementation will be developed in coordination with the Department.			
Indicator 15	Depression Remission at 12 months using standard PHQ-9	0710/NQF	Measured within each of the CMHCs contracted with the Contractor.
Indicator 16	Substance Use Screening Composite: Screening and Intervention	2597/SIM	Measured within each of the CMHCs contracted with the Contractor.
Indicator 17	Adolescent Health Risk Screening and Referral/coordination of care.	Department Defined	Measured within each of the CMHCs contracted with the Contractor.
Indicator 18	Develop a Person/Family Centered Advisory Council	Upon selection, the Department will work with the Contractor to define this measure.	Developed regionally with CMHCs/BHOs and the Department.

The Department will align performance measures with national measures whenever possible and will continue to work with the Contractor to develop the scope documents.

*New BHO contract requirement

Table 1. CCBHC State and/or CCBHC Required Reporting

Potential Source of Data	**Measure or Other Reporting Requirement**	**National Quality Forum Measure (# if endorsed)**
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	CCBHC Reported
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	**0418/ SIM CCBHC Reported (part of PHQ -9 symptom reduction measures)**
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	CCBHC Reported
Claims data/encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108- State Reported
Claims/Encounter Data	Anti-depressant Medication Management (CMS Core)	0105 State Reported

EXHIBIT I-1, EVALUATION AND TREATMENT OF COVERED METAL ILLNESS (MI) IN PEOPLE WITH TRAUMATIC BRAIN INJURY (TBI)

BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI).

People with traumatic brain injuries should be given the same access to mental health services as the general Medicaid population. The intent of this document is to make sure that a diagnosis of traumatic brain injury does not preclude an individual from receiving a diagnosis and treatment of a covered mental illness, if appropriate. As with any other population, individuals with TBI are at risk for increased symptoms, impairment, and disability without accurate assessment and appropriate treatment.

Although behavioral problems are not universal in the TBI population, many individuals with a TBI do experience problems with impulse control and self-management of their behavior. Clients may have problems with mood swings, depression, anxiety and psychosis. These problems can be related to the traumatic brain injury, reactive psychological processes and/or co-occurring mental illness diagnoses.

The high rate of co-occurring general medical conditions can further complicate the diagnostic profile and management for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's organic brain pathology, and/or mental illness covered under the Colorado Medicaid Community Mental Health Services Program is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document has been developed by several organizations with experience in this area. They include Behavioral Health Organizations (BHOs), the Department of Health Care Policy and Financing, traumatic brain injury treatment professionals, consumer advocates and other key stakeholders.

This document attempts to define criteria for service access and appropriate billing (capitation vs. fee for service) for use by evaluating clinicians and BHO/Community Mental Health Center (CMHC) administrators. It is not intended to fully describe the collaboration between providers, or between BHOs and other providers. All contributors to this document, including family members and advocates, embrace the value of systems working together.

The Colorado BHOs have adopted the following Practice Standards for Medicaid recipients with a traumatic brain injury:

1. Under no circumstance does the presence of TBI preclude an assessment for and treatment of co-occurring mental illness covered under the Colorado Medicaid Community Mental Health Services Program. BHOs will not deny services for a covered diagnosis on the basis that the covered diagnosis is not primary, and regardless of etiology. For example, a client presenting with post-traumatic stress disorder which developed as a result of a brain injury will be treated for the PTSD, regardless of whether or not the PTSD was caused from incident in which the brain injury occurred. The presence of a covered diagnosis and the BHO's determination that the issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A BHO provider will complete a face-to-face assessment with any child, youth, or adult with TBI who is referred for evaluation for covered mental illness according to the provider's regular intake and admission procedures and standards. For clients whose traumatic brain injury or level of functioning does not allow for the use of standard assessment procedures, the BHO will request needed information from other sources such as the client's providers, case manager, or family member when available. When these resources are not available, the BHO shall consult outside professionals with expertise in brain injury.

3. The BHO will ensure assessment on any re-referred client for whom the last assessment is older than 120 days.

4. If a consumer is referred for a second assessment within 120 days of being denied services as a result of the determination that their symptoms are not covered under the current contract, the BHO will consider the following when determining medical necessity:

a. There has been a change in the consumer's mental status, or
b. New and relevant information has been provided.

If so, the BHO will arrange for another mental health assessment based on the new information and/or mental status changes reported.

5. Referral for evaluation of Medicaid recipients with TBI can be made 24 hours a day, 7 days a week through the BHO's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the BHO. Emergency referrals may be evaluated either within a BHO network site or by BHO staff in a hospital Emergency Department or other safe environment. After hours emergency referrals are to be evaluated in a safe environment, usually in a hospital Emergency Department. BHO providers shall make reasonable efforts to contract with an expert in TBI in order to provide consultation.

7. If there are diagnostic uncertainties, all evaluations during regular working hours are reviewed by an experienced licensed professional within the BHO provider network. Any decision to deny services to a consumer with a traumatic brain injury will be reviewed by

the BHO Medical Director or physician designee. All after hours evaluations will be reviewed with the on-call psychiatrist prior to a denial being issued. In addition, BHO policy dictates that an initial appeal of any decision to deny a request for services requires that the denial be reviewed by a psychiatrist other than the psychiatrist who issued the first denial.

8. BHOs may utilize courtesy emergency evaluations from other BHOs. BHOs may also utilize hospital emergency department personnel to conduct an evaluation on a client outside the network area. If treatment is medically necessary (as defined in item #9 below) outside the network area, the BHO will negotiate an arrangement with a qualified provider to deliver the medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Colorado Medicaid Community Mental Health Services Program. Evidence that the referring symptoms are associated with that covered mental illness, evidence that treatment of the symptoms is medically necessary, and an assurance that treatment is provided within the least restrictive environment is necessary.

10. Services may be authorized either in whole or in part based upon determination of the underlying cause of the symptoms presented at the time. If it is determined that the individual does not have a covered diagnosis, the BHO will refer the individual to a specialist provider covered under the Medicaid fee for service program.

11. At the time of evaluation, the BHO will review all relevant and available information including records of past diagnoses and treatments. However, the BHO does not recognize "by history" diagnoses and will evaluate the provider's diagnostic formulation based on the prevalence of the medical evidence available at the time. If there is not enough evidence available to accept or challenge the diagnostic formulation of the provider, the BHO may defer its final authorization decision until sufficient information has been received. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

12. Cases in which the BHO evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary or not covered by the BHO, the consumer, family member, Case Manager and/or authorized representative will be given detailed written information about the clinical rationale for the denial. The BHO will also provide information about all available appeal rights and assistance with filing an appeal through the BHO.

14. The BHOs acknowledge that diagnoses often "evolve" over a period of time as the natural progression of a disorder further defines itself. Often, new, better, or more

complete clinical data is received and integrated into a comprehensive diagnostic formulation. In situations in which the provider changes a previous diagnostic formulation, the provider will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the BHO Medical Director or physician designee will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the BHO contract is the DSM-5 criteria for that diagnosis. While currently the ICD-10 is the standard by which diagnoses are coded for billing and reporting purposes, the DSM-5 remains the clinical standard by which diagnostic criteria are met and diagnoses are established. DSM-5 criteria must be met to support diagnoses even though billing and reporting will ultimately be submitted under ICD-10 codes. BHO contracted providers follow conventional diagnostic practice in considering whether diagnostic criteria are met, and consider that symptomatology may present atypically in individuals with a TBI. However, a diagnosis cannot be made in the absence of reasonably meeting criteria even in the context of an atypical presentation. Diagnostic evaluations will include a review of preexisting conditions, premorbid functioning, family medical and psychiatric history, prior treatment and evaluations, past and current response to treatment including prescribed medications, and past and current symptomatology and behavioral presentation as described by the individual, care providers, family members and other information sources.

2. Other diagnoses, including the traumatic brain injury, must be present to explain variances from diagnostic criteria.

3. Consideration is given to the consumer's abilities or disabilities in how diagnostic criteria present themselves.

4. Upon completion of a diagnostic evaluation as described in Guiding Principle #1, if a specific diagnosis is established with a reasonable degree of certainty, additional diagnoses will not be considered in authorizing services.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the consumer, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the consumer, and are provided in the least restrictive setting where services can safely be provided.

7. BHO Medicaid recipients with traumatic brain injury have access to the full spectrum of appeal rights under the Colorado Medicaid Community Mental Health Services Program for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary. Future review could involve expanding these guidelines.

EXHIBIT J-1, DEVELOPMENTAL DISABILITY (DD)

BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD)

Providing services to individuals with both a mental illness and a developmental disability is a complicated challenge to the provider community in meeting a DD/MI individual's behavioral health needs. Co-occurring mental health disorders and developmental disabilities are relatively common. People with developmental disabilities should be afforded the same access to mental health services as the general population. The intent of this document is to ensure that the presence of a diagnosis of developmental disability does not decrease the diagnostic significance of any accompanying mental illness. A misdiagnosis could result in the use of inappropriate or ineffective interventions.

Although behavioral problems are not universal among the DD population, many individuals with a developmental disability do show problems with impulse control, self-management of their behavior, and may have problems with mood swings, which may or may not be part of their developmental delay. The high rate of co-occurring neurological and general medical conditions can further complicate the diagnostic profile for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's developmental disability, organic brain pathology, and/or mental illness covered under the Colorado Medicaid Community Mental Health Services Program is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document has been developed by the Behavioral Health Organizations (BHOs) in collaboration with Community Center Boards (CCBs), developmental disability professionals, consumer advocates and other key stakeholders, in the interest of fulfilling their responsibilities under the Colorado Medicaid Community Mental Health Services Program, and to meet the BHO/HCPF contract requirement, which states, "The Contractor [BHO] shall develop written criteria for determining whether the need for mental health services for a Medicaid recipient with co-occurring mental illness and developmental Disabilities is a result of the individual's mental illness, or a result of the individual's developmental Disability…The criteria shall be approved by the Department." The document is an attempt to define these criteria for use by evaluating clinicians. It is not intended to fully describe the collaboration between providers, BHOs and CCBs, that is both required and embraced as values (and in most cases as a reality) by those organizations, by families, and by advocates for individuals with DD/MI. The Colorado BHOs have adopted the following Practice Standards for their Medicaid recipients with a developmental disability:

1. In no circumstance, does the presence of DD preclude an assessment for co-occurring mental illness covered under the Colorado Medicaid Community Mental Health Services Program. BHOs and their contracted providers will not deny services for a covered

diagnosis on the basis of that covered diagnosis not being primary. The presence of a covered diagnosis and the BHO's determination that the issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A BHO provider will complete a face-to-face assessment on any child, youth, or adult with DD who is referred for evaluation for covered mental illness according to that BHO's regular intake and admission procedures and standards. The BHO will provide a mental health assessment for any child, youth or adult with a developmental disability who is referred for evaluation of a covered mental illness. For consumers whose developmental disability and/or level of functioning precludes the use of standard evaluation protocols, the BHO will solicit the participation and/or assistance from someone, such as the CCB case manager, or family member, who can provide information needed to conduct the assessment. Evaluations will be conducted in a secure setting to ensure the safety of a consumer who is behaviorally out of control.

3. The BHO will complete a new face-to-face assessment on any re-referred consumer in which its last assessment is greater than 120 days old.

4. In the specific circumstance in which a BHO provider has assessed a consumer with DD within the past 120 days and services have been denied, and the consumer is re-referred for another assessment within that 120-day window, the BHO will re-assess whether there has either been a change in the consumer's mental status or if new and relevant information have been provided
.

5. Referral for evaluation of Medicaid recipients with DD can be made 24 hours a day, 7 days a week through the BHO's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the BHO. Emergency referrals may be evaluated either within a BHO network site or by BHO staff in a hospital Emergency Department or other safe environment. After-hours emergency referrals are evaluated in a safe environment, usually in a hospital Emergency Department.

7. All evaluations during regular working hours are reviewed by an experienced licensed professional within the BHO provider network if there are diagnostic uncertainties. Any decision to deny services to a consumer with a developmental disability will be reviewed by the BHO Medical Director or physician designee. All after-hours evaluations are reviewed with the on-call psychiatrist prior to a denial being issued. In all BHOs, an initial appeal of any decision to deny a request for services requires that the denial be reviewed by another psychiatrist other than the psychiatrist who issued the first denial.

8. BHOs may also utilize courtesy evaluations from other BHOs, and/or delegate emergency assessment to hospital emergency department personnel for Medicaid recipients requiring assessment outside their network areas. If treatment is medically necessary (as defined in item #9

below) outside the network area, the BHO will negotiate a single-case agreement or other non-network arrangement with a qualified provider to deliver that medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Colorado Medicaid Community Mental Health Services Program; and, evidence that the referring symptoms are associated with that covered mental illness, that treatment of the symptoms is medically necessary, and that it is provided within the least restrictive environment.

10. Services may be authorized either in whole or in part based upon the relative contribution of covered and non-covered (DD and/or organic brain pathology) conditions, and any collaborative arrangements in place between the BHO and the CCB involved with the individual.

11. At the time of evaluation, the BHO will review all relevant and available information including records of past diagnoses and treatments; however, the BHO will evaluate the provider's diagnostic formulation based on the preponderance of the medical evidence available at the time. If there is not adequate evidence available upon which to accept or challenge the diagnostic formulation of the provider, the BHO may defer its final authorization decision until sufficient information has been received. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

12. Cases in which the BHO evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary, the consumer, family member, CCB Case Manager and/or authorized representative will be given detailed written information, in accordance with HIPAA regulations, about the clinical rationale for the denial as well as information about all available appeal rights and assistance with filing an appeal through the BHO.

14. The BHOs acknowledge that diagnosis often "evolves" over a period of time as the natural progression of a disorder further defines itself ; and, as new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In all situations in which the provider changes a previous diagnostic formulation, they will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the BHO Medical Director will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the BHO contract is the DSM-5 criteria for that diagnosis. BHOs follow conventional diagnostic practice in considering whether DSM-5 criteria are met, and consider that DSM-5 symptomatology may present atypically in individuals with a developmental disability. However, a DSM-5 diagnosis cannot be made in the absence of reasonably meeting such criteria in the context of an atypical presentation. Diagnostic evaluations will include a review of prior treatment and evaluations, past and current response to prescribed medications, and past and current behavioral presentation as described by care providers, family members and other information sources.

2. Other diagnoses, including the developmental disability, must be present to explain variances from DSM-5 criteria.

3. Consideration is given to the consumer's abilities or disabilities in how DSM-5 criteria present themselves. The diagnostic process must be developmentally sensitive.

4. Additional diagnoses will not be considered in authorizing services when other known and clearly documented diagnoses sufficiently explain the clinical presentation of the consumer.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the consumer, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the consumer, and are provided in the least restrictive setting where services can safely be provided.

7. BHO Medicaid recipients with developmental disability have access to the full spectrum of appeal rights under the Colorado Medicaid Community Mental Health Services Program for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary.