Colorado Department of Health Care Policy and Financing

Solicitation #: 2015000052

Colorado Medicaid Utilization Management Program
CONTENTS

SECTION 1.0 INTRODUCTION ............................................................................................................. 3
  1.1. GENERAL INFORMATION ........................................................................................................ 3
  1.2. ANTICIPATED CONTRACT TERM ............................................................................................ 3

SECTION 2.0 TERMINOLOGY ............................................................................................................ 3
  2.1. ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY ............................................... 3

SECTION 3.0 BACKGROUND INFORMATION ................................................................................... 10
  3.1. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING ...................................... 10
  3.2. PROJECT BACKGROUND ........................................................................................................ 10
  3.3. FUTURE CONSIDERATIONS .................................................................................................... 13

SECTION 4.0 OFFEROR’S QUALIFICATIONS AND EXPERIENCE .................................................... 14
  4.1. MANDATORY QUALIFICATIONS ............................................................................................ 14
  4.2. ORGANIZATIONAL EXPERIENCE ......................................................................................... 14

SECTION 5.0 STATEMENT OF WORK ............................................................................................... 16
  5.1. CONTRACTOR’S GENERAL REQUIREMENTS ......................................................................... 16
  5.2. CONTRACTOR PERSONNEL ..................................................................................................... 24
  5.3. UM ANALYSIS AND STRATEGY DEVELOPMENT .................................................................... 31
  5.4. UTILIZATION REVIEW ............................................................................................................ 35
  5.5. TECHNOLOGY AND SYSTEM INTERFACE ............................................................................ 47
  5.6. CLIENT OVER-UTILIZATION PROGRAM (COUP) .................................................................. 55
  5.7. NURSE ADVICE LINE ............................................................................................................ 58
  5.8. INSPECTION, MONITORING AND SITE REVIEWS ................................................................. 61
  5.9. CORRECTIVE ACTION PLANS ................................................................................................. 62
  5.10. AD HOC PROJECTS .............................................................................................................. 64
  5.11. PERFORMANCE STANDARDS ............................................................................................... 65
  5.12. REPORTING REQUIREMENTS ............................................................................................... 68
  5.13. START-UP AND CLOSEOUT PERIODS ................................................................................. 75

SECTION 6.0 COMPENSATION AND INVOICING ........................................................................... 78
  6.1. COMPENSATION .................................................................................................................... 78
  6.2. INVOICING AND PAYMENT PROCEDURES ......................................................................... 80
  6.3. BUDGET .................................................................................................................................. 81

SECTION 7.0 EVALUATION METHODOLOGY .................................................................................. 82
7.1. EVALUATION PROCESS ................................................................. 82
7.2. EVALUATION COMMITTEE .......................................................... 82
7.3. COMPLIANCE ............................................................................ 83
7.4. PROPOSAL EVALUATION CRITERIA ......................................... 83

APPENDIX A - ADMINISTRATIVE INFORMATION DOCUMENT
APPENDIX B – DRAFT CONTRACT
APPENDIX C – W-9 FORM
APPENDIX D – PRICING WORKSHEET
APPENDIX E – APPEALS DATA FY 13-14
APPENDIX F - PEDIATRIC HOME ASSESSMENT TOOL
APPENDIX G – PEDIATRIC PERSONAL CARE SERVICES
APPENDIX H – MEDICAID CASELOAD
APPENDIX I – PRIOR AUTHORIZATION REVIEW EXPLANATIONS
APPENDIX J – PDN ACUITY TOOL
APPENDIX K - COUP CLIENT BREAKDOWN
APPENDIX L - EMERGENCY DEPARTMENT UTILIZATION REPORT
APPENDIX M - PAR TECHNICAL DENIAL HISTORY
APPENDIX N - NURSE ADVICE LINE
APPENDIX O - CLIENT OVERUTILIZATION PROGRAM REPORT
APPENDIX P - 3 YEAR PAR HISTORY – APPROVALS AND DENIALS
SECTION 1.0 INTRODUCTION

1.1. GENERAL INFORMATION

1.1.1. The Colorado Department of Health Care Policy and Financing (Department) is soliciting competitive, responsive proposals from experienced and financially sound organizations to perform as the Utilization Management (UM) Contractor for the Department.

1.1.2. General solicitation information, timelines and proposal submission requirements are available in Appendix A, Administrative Information Document. To be considered responsive, an Offeror shall comply with all of the requirements and timelines contained in Appendix A.

1.2. ANTICIPATED CONTRACT TERM

1.2.1. The Contractor’s start-up period is anticipated to begin on January 1, 2015 and end on June 30, 2015.

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

1.2.3. The total duration of the Contract, from the Operational Start Date until termination, and including the Department’s exercise of any options, is not anticipated to exceed five (5) years. The Department may extend the Contract beyond the anticipated term in this subsection, in accordance with the Colorado Procurement Code and its implementing rules, in the event that the Department determines the extension is necessary to align the Contract with other Department contracts, to address State or Federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.

SECTION 2.0 TERMINOLOGY

2.1. ACRONYMS, ABBREVIATIONS AND OTHER TERMINOLOGY

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

2.1.1.1. 278 and 278U Transactions - The electronic transactions that are HIPAA compliant to send a request for utilization review (278) and send a response to the request for utilization review (278U).

2.1.1.2. Accountable Care Collaborative (ACC) Program –The Department’s program to improve ACC Members health and reduce costs. The ACC is Colorado Medicaid’s primary delivery system for reform and innovation. The program is comprised of three (3) components: Regional Care Collaborative Organizations (RCCOs), Statewide Data and Analytics Contractor (SDAC), and Primary Care Medical Providers (PCMPs).

2.1.1.3. ACC Member: A Medicaid Client enrolled in the Regional Care Collaborative Organizations (RCCO).

2.1.1.4. Automated Review - A review of a Prior Authorization Request that is completed by algorithm-based utilization review software and can provide real-time determinations (approvals and technical denials).
2.1.1.5. All Patient Refined Diagnosis Related Groups (APR-DRG) - A classification payment system that classifies and reimburses hospital inpatient stays according to the reason for admission, severity of illness and risk of mortality. The Department began the use of APR-DRGs on January 1, 2014.

2.1.1.6. Behavioral Health Organizations (BHO) – A BHO arranges or provides medically necessary behavioral health services to clients in their service areas, which includes comprehensive mental health and substance use disorder services. Medicaid Clients are assigned to a BHO based upon where they live.

2.1.1.7. Benefit Coverage Standards – Outline of the appropriate amount, scope and duration of Medicaid services to set reasonable limits on those services and promote the health and functioning of Medicaid Clients.

2.1.1.8. BUS - Benefits Utilization System. The BUS is an electronic record system managed by the Colorado Governor's Office of Information Technology by and for the Department. The BUS is the official document of record for Long Term Services and Support (LTSS), functional level of care determination, service benefits planning, program certification and case management operations.

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

2.1.1.9.1. New Year's Day.
2.1.1.9.2. Martin Luther King, Jr. Day.
2.1.1.9.3. Washington-Lincoln Day (Commonly known as President’s Day).
2.1.1.9.4. Memorial Day.
2.1.1.9.5. Independence Day.
2.1.1.9.6. Labor Day.
2.1.1.9.7. Columbus Day.
2.1.1.9.8. Veterans’ Day.
2.1.1.9.9. Thanksgiving Day.
2.1.1.9.10. Christmas Day.

2.1.1.10. Business Hours - 8:00 a.m. – 5:00 p.m. Mountain Time (MT) each Business Day.

2.1.1.11. 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, or computer virus.

2.1.1.12. Call Disposition - The outcome of a Client’s call to the Nurse Advice Line, including the Client’s intention to seek services at the end of the call.

2.1.1.13. Centers for Medicare and Medicaid Services (CMS) - The federal agency responsible for oversight of all state Medicaid programs.

2.1.1.15.  CHP+ - The Colorado Child Health Plan Plus. CHP+ is the marketing name for the Colorado Children’s Basic Health Plan program.

2.1.1.16.  Client - Any individual enrolled in the Colorado Medicaid program.

2.1.1.17.  Client Over-Utilization Program (COUP) - A program for Colorado Medicaid Clients who are shown, through development and review of Client utilization patterns and profiles, to have a history of unnecessary or inappropriate utilization of care and services. Clients in this program are locked into a specific set of Providers that will help the Client access care appropriately and safeguard against over-utilization of benefits.

2.1.1.18.  Closed Code – Any service or item that is not considered a state benefit.

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

2.1.1.20.  Contract - The agreement that is entered into as a result of this solicitation.

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

2.1.1.22.  Covered Services - Medicaid benefits according to the State Plan, descriptions of which are provided in benefit coverage standards, policy statements, the Code of Colorado Regulations, billing manuals and provider bulletins.

2.1.1.23.  Current MMIS – The MMIS that is operational as of the Effective Date. As of the Effective Date the Current MMIS is operated and maintained by Xerox State Healthcare, LLC.

2.1.1.24.  Durable Medical Equipment (DME) - Any medical equipment used in the home to aid in a better quality of living.

2.1.1.25.  Department - The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado that administers Colorado Medicaid.

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

2.1.1.27.  Early Periodic Screening, Diagnosis, and Treatment (EPSDT) - A comprehensive and preventative child health program for Clients ages twenty (20) and under. States are required to provide any medically necessary, non-experimental services to correct or ameliorate any physical or mental conditions even if not covered by the State’s plan.

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

2.1.1.29.  Emergency Services - Covered inpatient and outpatient services that are needed to evaluate or stabilize a medical condition in which the absence of immediate medical attention will lead to death or serious impairment of a bodily organ or part.
2.1.1.30. Expedited Review - A Prior Authorization Request review that is required to be done on an expedited basis because a delay could: (a) seriously jeopardize the life or health of the Client or the ability of the Client to regain maximum function, or (b) in the opinion of a physician with knowledge of the Client’s medical condition, would subject the Client to severe pain; and cannot be adequately managed without the care or treatment that is the subject of the claim. An Expedited Review request may also be referred to as an urgent review request.

2.1.1.31. Failure to Appear (FTA) – The failure of an appellant or appellee to appear for an administrative hearing at the designated date and time.

2.1.1.32. Fee-For-Service (FFS) - A Provider payment mechanism in which Providers are reimbursed a fee for each service they provide such as an office visit, test, procedure, or other health care service.

2.1.1.33. Fiscal Agent - The Contractor that operates and maintains the Department’s Medicaid Management Information System (MMIS).

2.1.1.34. Fiscal Agent Provider Web Portal - The web portal site managed by the Department’s Fiscal Agent through which Colorado Medicaid Providers submit claims and verify Client eligibility.

2.1.1.35. Future MMIS – The Department’s new MMIS that is being developed as of the Effective Date and is expected to be operational November 1, 2016. As of the Effective Date the Future MMIS is being developed and implemented by HP Enterprise Services.


2.1.1.37. Health Information Technology (HIT) - Electronic systems that allow for comprehensive management of medical information and the secure exchange of health care data and records.

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

2.1.1.39. Hospital Readmission - A subsequent admission to the hospital during a designated period of time after a Client has been discharged from the hospital. May be defined as anywhere from twenty-four (24) hours after discharge from the first hospital stay up to thirty (30) days. Currently, it is the Department’s policy to deny reimbursement for hospital readmission that occurs within twenty-four hours of discharge if the admitting diagnoses are related to the same condition.

2.1.1.40. InterChange – The name for the Department’s future MMIS system which is currently under development.

2.1.1.41. Key Performance Indicators (KPI) - The utilization, quality and process measures on which RCCOs and PCMPs are tracked.

2.1.1.42. Key Personnel - The position or positions that are specifically designated as such in the Contract.
2.1.1.43. Lock-In Provider – A Provider that will serve as the case manager for Client’s identified for the Client Overutilization Program (COUP). The Lock-In Provider will authorize and monitor all services rendered to the COUP Client by any other Provider.

2.1.1.44. Long Term Home Health (LTHH) - Medically necessary care performed in the home beyond sixty (60) days.

2.1.1.45. Manual Review – A review of a Prior Authorization Request (PAR) that is completed by a Registered Nurse (RN) and/or a Physician reviewer for a determination of medical necessity. PARs that are not completed by algorithm-based utilization review software.

2.1.1.46. Medicaid Management Information System (MMIS) - The Department’s automated claims processing system required under federal regulations. This term shall include both the Current MMIS and the Future MMIS.

2.1.1.47. Medical Home - A Provider that gives comprehensive primary-care, including the facilitation of partnerships among individual Client’s specialists and other Providers, and when appropriate, the Client’s family.

2.1.1.48. Nurse Advice Line - Department’s 24-hour phone line that provides triage and health information services to Clients, and gives the Contractor an opportunity to educate Clients about how to seek care according to evidence-based guidelines.

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

2.1.1.50. Office Administered Drugs - Injections that can be given intravenously, subcutaneously, or intramuscularly in a physician’s office and are often referred to as J codes but may include HCPCS that start with a C, J, Q, or S.

2.1.1.51. Outlier Days - The days in a hospital stay which occur after the long stay trim point, which is defined on the All Patient Refined Diagnosis Related Groups (APR-DRG) schedule for each APR-DRG.

2.1.1.52. Operational Start Date - The later of July 1, 2015 or when the Department authorizes the Contractor to begin fulfilling its obligations under the Contract.

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

2.1.1.54. Prior Authorization Revision - Changing a current, approved prior authorization in the system as a result of, but not limited to, the addition of units, an appeal decision, a change of Provider, a Peer-To-Peer or Reconsideration determination, or a Department decision to extend a prior authorization.

2.1.1.55. Peer-to-Peer - Process for the Provider to discuss a denial determination of a prior authorization with the Contractor’s physician. Requests must be made by the Provider, within five (5) calendar days after a denial decision. This review may also include the submission of additional clinical information for review, if submitted within the first five (5) calendar days, following a denial decision.
2.1.1.56. Pediatric Assessment Tool (PAT) - Tool used to assess a Client’s medically necessary skilled care needs for Home Health services provided in the Client’s home by either a Registered Nurse (RN) and/or a Certified Nurse Aide (CNA). The PAT is administered for Clients under the age of twenty one (21).

2.1.1.57. Personal Care Assessment Tool (PCAT) - Tool used to assess a Client’s medically necessary unskilled care needs provided in a Client’s home by a Personal Care worker.

2.1.1.58. PHI - Protected Health Information.

2.1.1.59. Primary Care Medical Provider (PCMP) - A Medicaid enrolled primary care Provider who serves as a Medical Home for ACC Members. PCMPs can be Federally Qualified Health Centers, Rural Health Clinics, clinics or other group practices that provide the majority of a Member’s comprehensive primary, preventive and medical care. Individual PCMPs or pods 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.

2.1.1.60. Private Duty Nursing (PDN) Tool - Tool used to assess a Client’s need for Private Duty Nursing services provided by a Registered Nurse in the Client’s home.

2.1.1.61. Prior Authorization Request (PAR) – Process of obtaining prior approval of requested services to determine whether those services are a covered benefit or medically necessary.

2.1.1.62. Prospective Review - A prior assessment to determine if requested services are appropriate for a particular Client, or the category of service is covered. Provider - Any health care professional or entity that has been accepted as a provider in the Colorado Medicaid program.

2.1.1.63. Reconsideration - The process by which a Provider can request a revision to the Contractor’s PAR denial or partial denial determination, which requires additional review. This is a second review by a different physician that must be requested by the Provider within ten (10) calendar days of the denial or partial denial decision. The review must be completed by a physician of the same profession and specialty as the service being requested. This review may also include the submission of additional clinical information for review if submitted within the first five (10) calendar days following a denial decision.

2.1.1.64. Referral - Any form or written communication by a Provider that recommends specific specialist ancillary services.

2.1.1.65. Regional Care Collaborative Organizations (RCCOs) - The regionally-based entities with whom the Department contracts with to administer the ACC Program on a regional basis. The RCCOs will be responsible for accountable care, care that improves the health of ACC Members and controls costs.

2.1.1.66. Retrospective Review - The process of determining coverage for a clinical service by applying criteria to support claims adjudication after the opportunity for prior authorization or concurrent review has passed, services have already been provided and payment has already been made.
2.1.1.67. Review Notification - Communicating the result of a Prior Authorization Request to the Provider, the Client and the Department’s Fiscal Agent.

2.1.1.68. Secure File Transfer Protocol (SFTP) - A secure version of File Transfer Protocol (FTP) which facilitates data access and data transfer over a Secure Shell (SSH) data stream.

2.1.1.69. Serious Reportable Event - A hospital-acquired condition (HAC) that was not present on admission to the hospital as an inpatient, that alters the condition or diagnosis of the Client receiving care and that will not be reimbursed by the Department.

2.1.1.70. Smart PAR Submission - An electronic mechanism for instantly notifying a Provider when a Prior Authorization is either approved, partially approved, and/or is incomplete or insufficient to complete the review.

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

2.1.1.72. State Fiscal Year (SFY) - The twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year.

2.1.1.73. Statewide Data and Analytics Contractor (SDAC) - The entity with whom the Department contracts to provide data aggregation, analysis and distribution in support of the ACC Program.

2.1.1.74. Subcontractor - Third-parties, if any, engaged by Contractor to aid in performance of its obligations under the Contract.

2.1.1.75. Technical Denial - A denial of a Prior Authorization Request (PAR) due to missing, inadequate, or incorrect information on the PAR.

2.1.1.76. Turnaround Time - The amount of time between the receipt of a complete Prior Authorization Request and the subsequent Review Notification. A complete Prior Authorization Request is when all necessary documentation has been received from the Provider. For purposes of tracking Turnaround Time, day one (1) begins on the first Business Day during Business Hours that the complete Prior Authorization Request is in possession of the Contractor.

2.1.1.77. Uptime - Periods of time when the Web Portal application and the supporting computing infrastructure under the Contractor’s control are operating normally. If the Web Portal is operating normally and yet unavailable to users because of incidents in infrastructure components that the Contractor does not control, this shall also be considered Uptime.

2.1.1.78. Utilization Management (UM)/Utilization Management Program (UM Program) - The function of reviewing the appropriateness of the use, consumption and outcomes of services, along with level and intensity of care, using utilization review techniques that focus on:

2.1.1.78.1. Using evidence-guided clinical practices, translating rigorous research and drawing on change management practices to achieve measurable cost efficiencies and gains in Client safety and health outcomes.
2.1.1.78.2. Automating UM processes using a UM Provider Web Portal and other advanced technologies for greater transparency, speed, clinical accuracy and stakeholder satisfaction, including Clients and the Providers who serve them.

2.1.1.78.3. Utilizing enhanced analytics to strategically identify and address appropriate and inappropriate utilization patterns as a basis for decision-making when proposing and implementing broad-based and targeted UM processes and procedures.

2.1.1.78.4. Adopting UM best practices, identifying and rapidly implementing those that lead to the most improvement in Client health outcomes and potential return-on-investment (ROI).

2.1.1.78.5. Engaging Providers and Clients in facilitated discussions about how Providers and Clients can work individually and together to utilize care appropriately, to improve Client health outcomes and reduce inappropriate resource utilization.

2.1.1.79. Utilization Management (UM) Provider Web Portal – The web portal site managed by the Contractor through which Colorado Medicaid Providers submit PARs.


2.1.1.81. Warning Period – Period of time beginning when a Client is first identified as fulfilling COUP criteria and is sent a warning letter and ending on the next quarter’s data pull when the Client is either determined to still meet COUP criteria and is enrolled in COUP or is determined to no longer meet COUP criteria.

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

SECTION 3.0 BACKGROUND INFORMATION

3.1. THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

3.1.1. The Department serves as the Medicaid Single State Agency. The Department develops and implements policy and financing for Medicaid and the Children’s Health Insurance Program, called Child Health Plan Plus (CHP+) in Colorado, as well as a variety of other publicly funded health care programs for Colorado's low-income individuals, families, children, pregnant women, the elderly and people with disabilities. For more information about the Department, visit www.Colorado.gov/HCPF.

3.1.2. The Department is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

3.2. PROJECT BACKGROUND

3.2.1. Colorado Medicaid Program

3.2.1.1. Colorado Medicaid has a caseload of over nine hundred seventy thousand (970,000) Clients as of May 2014. During recent months, enrollment in public health insurance and safety net programs has increased rapidly. Colorado is operating a State-based Marketplace, known as Connect for Health Colorado. Colorado expanded Medicaid coverage to low-income adults on January 1, 2014. Information about Colorado Medicaid’s caseload may be found in Appendix H, Medicaid Caseload.
3.2.1.2. Given this rapid growth, the Department is committed to administering a Medicaid program for all eligible Clients that focuses on the provision of accountable health care by improving health outcomes and controlling costs responsibly. The Department is shifting from a system of care that rewards Providers for the volume of services to one that places emphasis on accountability for improved health outcomes and controlled costs, focusing on care coordination and Medical Home services that provide the right care at the right time and in the right setting. With this emphasis on accountable care, and increasing caseloads, and the ongoing responsibility to manage and monitor Medicaid service utilization, the Department seeks to contract with a Contractor that will be able to fulfill the Department’s goal of UM modernization. As such, it is important to understand the history of the Department’s efforts to modernize the UM Program and to understand how the UM Program must be consistently operated and aligned with other Department initiatives and statewide collaborations.

3.2.1.3. The work stated in this Contract will be performed for all Department Medicaid programs with the exception of managed care programs. The managed care programs perform their own utilization management services.

3.2.2. The Accountable Care Collaborative (ACC) Program

3.2.2.1. The ACC Program is the Department's primary mechanism for Medicaid reform in Colorado. The Department currently serves approximately six hundred thousand (600,000) Medicaid Clients through the ACC Program. It is envisioned that the ACC Program will serve a progressively-larger proportion of all Medicaid Clients in Colorado in future years. In response to the changing health care environment, the ACC Program was designed to foster accountability by improving health outcomes and controlling costs, while focusing on the following objectives:

3.2.2.1.1. Expanding access to comprehensive primary care for Clients.
3.2.2.1.2. Providing a focal point of care/Medical Home which provides coordinated care and integrated access for Clients.
3.2.2.1.3. Ensuring a positive Client and Provider experience while promoting the engagement of both Clients and Providers.
3.2.2.1.4. Effectively applying an unprecedented level of statewide data and analytics functionality to support secure data-sharing and to enable the near-to-real-time monitoring and measurement of health care costs, trends and outcomes.

3.2.2.2. A fundamental premise of the ACC Program is that regional communities are in the best position to make decisions to address the cost and quality problems resulting from the previous system of fragmented care, variation in practice patterns and volume-based payment systems. The ACC Program is designed to support the infrastructure necessary to shift delivery systems away from fragmented, volume-driven "sick care" and towards coordinated, accountable, outcomes-based care.

3.2.2.3. Central to the ACC Program is the interaction among three key roles:

3.2.2.3.1. Regional Care Collaborative Care Organizations (RCCOs). Each RCCO is responsible for ensuring accountable care and enhancing care coordination for Clients within the region.
3.2.3.2. The Statewide Data and Analytics Contractor (SDAC). The SDAC is responsible for bringing a new level of information and data analytics to the Medicaid program, providing insight into variations within and across RCCOs, benchmarking across Key Performance Indicators and serving as a conduit for health information exchange between the Department and the RCCOs.

3.2.3.3. Primary Care Medical Providers (PCMPs) will serve as focal points of care and provide comprehensive primary care for Medicaid Clients enrolled in the ACC Program.

3.2.3.4. Additional information on the ACC Program can be found on the Department's Web site at [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf) → Initiatives → Accountable Care Collaborative.

3.2.3. Benefits Collaborative

3.2.3.1. Over the past five (5) years, the Department has developed and implemented a process whereby Medicaid benefits are clearly defined and documented in language and formats that can be easily understood by Clients and Providers alike. This transparent and collaborative process seeks to bring together subject matter experts, Providers, Clients and other stakeholders to discuss and determine appropriate benefit coverage policies including amount, scope and duration of services.

3.2.3.2. The Benefits Collaborative meetings occur an average of four (4) times per month for two (2) hours.

3.2.4. Long Term Home Health

3.2.4.1. As of February 2014, an estimated three thousand five hundred (3,500) Clients utilize Acute and Long Term Home Health (LTHH) services.

3.2.4.2. As of June, 2014 an estimated five hundred and fifty (550) Clients utilize Private Duty Nursing (PDN) through Medicaid.

3.2.4.3. All Long Term Home Health services are requested and evaluated by home health agencies using the following standardized tools: Private Duty Nursing Tool (PDN), Pediatric Assessment Tool (PAT) and/or the Personal Care Assessment Tool (PCAT).

3.2.4.3.1. The PCAT is currently under development with an expected go-live date of January 1, 2015.

3.2.4.4. Long Term Home Health services are requested for a duration of twelve (12) months unless the client has a change in condition.

3.2.4.5. As of February 2014, it is estimated that when the program goes live January, 2015, two thousand six hundred and seventy (2,670) Clients will use Personal Care services.

3.2.4.6. As of February 2014, an estimated one thousand eight hundred (1,800) Clients utilize home CNA and RN services.

3.2.4.7. A manual review, using the PDN or PAT tools, takes at least thirty (30) minutes per review by the incumbent UM contractor. A client may receive PDN, PAT, or PCAT services concurrently.

3.2.5. Medicaid Management Information System
3.2.5.1. The Department’s Current MMIS is a mainframe claims processing system capable of receiving Prior Authorizations electronically via the ANSI ASC X12N V5010 278 Unsolicited Review Notification and Acknowledgement. (278U) transaction set.

3.2.5.1.1. The incumbent UM vendor sends up to four (4) separate batches of electronic Prior Authorizations to Xerox on a daily basis using the 278U transaction and the Current MMIS sends four (4) acknowledgement files back to the UM vendor with Prior Authorization status as determined by the Current MMIS, Prior Authorization IDs and any error messages stopping the acceptance of a Prior Authorization into the Current MMIS.

3.2.5.2. Once a Prior Authorization has been accepted into the Current MMIS, either manually or via the 278U transaction, any modifications to content must be performed manually in the Production environment. All Prior Authorizations sent via the 278U transaction that have errors that impede their acceptance into the Current MMIS also require manual intervention.

3.2.5.3. Once the Current MMIS has received the files it sends Vendors an electronic acknowledgement. Once processed, acknowledgement of the processed Prior Authorization is transmitted to Providers once daily via an electronic or paper form letter. Paper letters are sent via First Class mail.

3.2.5.4. Clients are notified of Prior Authorization status via First Class mail only.

3.2.5.5. Provider and Client letters identify the Client’s name, requested service, appropriate appeal rights and any MMIS-generated reasons for denial.

3.2.5.6. The Department verifies client eligibility during claims processing. While the Current MMIS verifies whether all Provider and Client information is valid during Prior Authorization processing, it does not deny Prior Authorizations on the basis of Client ineligibility. Further, claims processing assumes the medical necessity of the procedure or service has been determined during the Prior Authorization Process.

3.2.5.7. The Department has executed a contract with HP Enterprise Services to implement the Future MMIS beginning in November of 2016. The Contactor shall be required to test and transmit, Prior Authorizations with Xerox State Health Care, LLC and HP Enterprise Services during the contract term. All Work must be completed during the transition period between MMIS vendors.

3.2.5.8. The Department will release information about the HP Enterprise Services system functionality as it is made available.

3.2.6. Colorado Medicaid Nurse Advice Line

3.2.6.1. The Colorado Medicaid Nurse Advice Line is currently run by Denver Health. For questions regarding the Nurse Advice Line Offerors may contact Michaele Johnson, Denver Health Business Manager, at 303-389-1276 or Michaele.Johnson@rmpdc.org.

3.3. FUTURE CONSIDERATIONS

3.3.1. Salesforce Data Transmission
3.3.1.1. The Department currently uses a Salesforce database in its Healthy Communities program. The Department reserves the right to include the transmission of NAL data to Salesforce, or another similar system used by the Department in the future, as part of the management of the Nurse Advice Line. This work may be added to the Contract in consultation with the Contractor, by an amendment to the Contract.

3.3.2. Behavioral Health

3.3.2.1. As the Department moves toward better integration of physical, behavioral, dental and public health services the Department reserves the right to expand the type and scope of services in the Contract beyond the current focus on physical health care. Additional work may be added to the Contract in consultation with the Contractor, by an amendment to the Contract.

3.3.3. Long Term Services and Support Utilization Management

3.3.3.1. The Department currently performs utilization management for Long Term Services and Supports Waiver Programs such as the Children’s Home and Community Based Services (CHCBS) and the Children’s Extensive Support – Home and Community Based Services (HCBS-CES) waivers. The Department reserves the right to expand the scope of the Contract to include UM activities for these waiver programs, either as a manual paper process or an electronic process, in consultation with the Contractor, by an amendment to the Contract.

SECTION 4.0 OFFEROR'S QUALIFICATIONS AND EXPERIENCE

4.1. MANDATORY QUALIFICATIONS

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

4.1.1.1. The Offeror shall be designated by the federal Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization (QIO) or be currently certified by CMS as a QIO-like entity.

4.2. ORGANIZATIONAL EXPERIENCE

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

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

4.2.2.1.1. Experience within the last five (5) years administering a UM program for state Medicaid programs.

4.2.2.1.2. Experience managing a UM program similar in size and scope to Colorado Medicaid.

4.2.2.1.3. Experience analyzing health care data to identify the greatest opportunities for impact in reducing inappropriate utilization of services.

4.2.2.1.4. Experience designing strategies to address areas of inappropriate utilization.
4.2.2.1.5. Experience working with partners to help Providers adopt and implement new UM practices.

4.2.2.1.6. Experience creating algorithms as well as developing and implementing the technology necessary to do Automated Review of Prior Authorization Requests (PARs) and reducing the administrative burden on Providers.

4.2.2.1.7. Experience successfully managing health care costs for Medicaid.

4.2.2.1.8. Experience performing Prospective reviews of clinical health care data and/or prior authorizations for medical necessity as well as consulting other policy coverage documents to ensure coverage determinations are consistent with clinical practice and program policy.

4.2.2.1.9. Experience creating, maintaining and/or updating a web portal in which Providers can submit Prior Authorization Requests to the Offeror for both manual and automated review.

4.2.2.1.10. Experience working with claims systems to track and communicate review results to Providers.

OFFEROR'S RESPONSE 1. Provide details that demonstrate how Offeror meets all mandatory qualification requirements listed in Section 4.1. If the Offeror is a designated QIO, the Offeror’s response shall contain documentation of that designation. If the Offeror is certified as a QIO-like entity by CMS, then the Offeror’s response shall include documentation of the Offeror’s current certification.

OFFEROR'S RESPONSE 2. Provide a detailed description of at least one (1) and no more than four (4) UM projects. For each of the projects described, include the Offeror’s experience with each of the following:

a. Experience within the last five (5) years administering a UM program for state Medicaid programs.

b. Experience managing a UM program similar in size and scope to Colorado Medicaid. Include the number of Clients that the program covered.

c. Experience in analyzing health care data to identify the greatest opportunities for impact in reducing inappropriate utilization of services.

d. Experience in designing strategies to address areas of inappropriate utilization.

e. Experience in working with partners to help Providers adopt and implement new UM practices.

f. Experience in creating algorithms as well as developing and implementing the technology necessary to do Automated Review of PARs.

g. Experience in successfully managing costs for Medicaid and reducing the administrative burden on Providers and payors.
h. Experience working with claims systems to track and communicate review results to Providers.

i. Experience creating, maintaining and/or updating a web portal in which Providers can submit Prior Authorization Requests to the Offeror for both manual and automated review.

j. Experience performing Prospective reviews of clinical health care data and/or prior authorizations for medical necessity as well as consulting other policy coverage documents to ensure coverage determinations are consistent with clinical practice and program policy.

k. Experience processing PARs manually by qualified registered nurses and physicians.

I. For each project include the following information:
   i. The name and location of the Client and the number of years performing for the Client.
   ii. The nature of the project, including the services provided and the number of members/recipients covered, and how the organization used health and expenditure data to guide the activities of the UM program and reduce inappropriate utilization. Describe the strategies the Offeror used to address areas of inappropriate utilization and how the Offeror worked with key partners to implement the strategies.
   iii. Any corrective action plans entered into over the course of the project, or any findings related to contract non-compliance or deficient performance.

SECTION 5.0 STATEMENT OF WORK

5.1. CONTRACTOR’S GENERAL REQUIREMENTS

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

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

5.1.3. The Contractor shall work cooperatively with key Department staff and, if applicable, the staff of other Department contractors or other State agencies to ensure the completion of the Work. The Department may, in its sole discretion, use other contractors to perform activities related to the Work that are not contained in the Contract or to perform any of the Department’s responsibilities. In the event of a conflict between the Contractor and any other Department contractor, the Department will resolve the conflict and the Contractor shall abide by the resolution provided by the Department.
5.1.4. The Contractor shall inform the Department on current trends and issues in the healthcare marketplace and provide information on new technologies in use that may impact the Contractor’s responsibilities under this Contract.

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

5.1.6. If the Contractor is designated as a QIO by CMS, then the Contractor shall maintain its designation as a Quality Improvement Organization (QIO) for the entire term of the Contract. If the Contractor is certified as a QIO-like entity by CMS, then the Contractor shall maintain its certification as QIO-like entity for the entire Contract term.

5.1.7. Deliverables

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

5.1.7.2. Each deliverable will follow the deliverable submission process as follows:

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

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

5.1.7.2.2.1. 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.

5.1.7.2.2.2. 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.

5.1.7.2.3. 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 in writing. A deliverable shall not be deemed accepted prior to the Department’s notice to the Contractor of its acceptance of that deliverable.

5.1.7.3. The Contractor shall employ an internal quality control process to ensure that all deliverables, documents and calculations are complete, accurate, easy to understand and of high quality. The Contractor shall provide deliverables that, at a minimum, are responsive to the specific requirements for that deliverable, organized into a logical order, contain no spelling or grammatical errors, are formatted uniformly and contain accurate information and correct calculations. The Contractor shall retain all draft and marked-up documents and checklists utilized in reviewing deliverables for reference.
5.1.7.4. In the event that any due date for a deliverable falls on a day that is not a Business Day, then the due date shall be automatically extended to the next Business Day, unless otherwise directed by the Department.

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

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

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

5.1.7.7.1. Any deliverable described as an update of another deliverable shall be considered a version of the original deliverable for the purposes of this subsection.

5.1.7.8. In the event that the Contractor becomes aware of any milestone or timelines in any deliverable that will not be met, for any reason, the Contractor shall notify the Department of the delay within twenty four (24) hours.

5.1.8. Stated Deliverables and Performance Standards

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

5.1.9. Communication Requirements

5.1.9.1. Communication with the Department

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

5.1.9.1.2. The Contractor shall establish a secure file transfer protocol (SFTP) for data transfers at the request of the Department.
5.1.9.1.3. The Department will use a transmittal process to provide the Contractor with official direction within the scope of the Contract. The Contractor shall comply with all direction contained within a completed transmittal. For a transmittal to be considered complete, it must include, at a minimum, all of the following:

5.1.9.1.3.1. The date the transmittal will be effective.

5.1.9.1.3.2. Direction to the Contractor regarding performance under the Contract.

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

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

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

5.1.9.1.4. The Contractor shall accept file transmittals from the Department’s Fiscal Agent and the Department regarding Client eligibility. The Contractor shall accept the file in the formats provided by the Fiscal Agent without any modifications to the file by either the Fiscal Agent or the Department.

5.1.9.1.5. The Contractor shall accept data files regardless of size and shall have the ability to read all included data.

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

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

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

5.1.9.1.8. In the event that the Contractor receives direction from the Department outside of the transmittal process, it shall contact the Department’s primary designee, or backup designees if the primary designee is unavailable, and have the Department confirm that direction through a transmittal prior to complying with that direction.
5.1.9.1.9. Transmittals may not be used in place of an amendment, and may not, under any circumstances be used to modify the term of the Contract or any compensation under the Contract. Transmittals are not intended to be the sole means of communication between the Department and the Contractor, and the Department may provide day-to-day communication to the Contractor without using a transmittal.

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

5.1.9.2. Communication with Clients, Providers and Other Entities

5.1.9.2.1. The Contractor shall create a Communication Plan that includes, but is not limited to, all of the following:

5.1.9.2.1.1. A description of how the Contractor will communicate to Clients any changes to the services those Clients will receive or how those Clients will receive the services.

5.1.9.2.1.2. 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.

5.1.9.2.1.3. The specific means of immediate communication with Clients and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

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

5.1.9.2.1.5. A listing of the following individuals within the Contractor’s organization, that includes cell phone numbers and email addresses:

5.1.9.2.1.5.1. 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.

5.1.9.2.1.5.2. An individual who is responsible for any website or marketing related to the Work.

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

5.1.9.2.2. The Contractor shall deliver the Communication Plan to the Department for review and approval.

5.1.9.2.2.1. DELIVERABLE: Communication Plan

5.1.9.2.2.2. DUE: Within ten (10) Business Days after the Effective Date
5.1.9.2.3. 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.

5.1.9.2.3.1. DELIVERABLE: Annual Communication Plan Update

5.1.9.2.3.2. DUE: Annually, by June 30th of each year

5.1.9.2.4. 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 also modify the Communication Plan as directed by the Department. The Contractor shall submit all Interim Communication Plan Update to the Department for review and approval.

5.1.9.2.4.1. DELIVERABLE: Interim Communication Plan Update

5.1.9.2.4.2. 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

5.1.9.2.5. The Contractor shall not implement any Communication Plan, Annual Communication Plan Update or Interim Communication Plan Update prior to receipt of the Department’s written approval of that Communication Plan, Annual Communication Plan Update or Interim Communication Plan Update. The Contractor shall comply with all requirements, deliverables and milestones contained in the most recently implemented Communication Plan, Annual Communication Plan Update or Interim Communication Plan Update.

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

5.1.9.2.7. The Department’s new MMIS, Colorado interChange is anticipated to be implemented in October 2016. Once the new MMIS is implemented the Contractor shall include the use of communication with Providers through that system at the direction of the Department. This may include, but is not limited to, communication through the new MMIS’s Provider Healthcare Portal.

5.1.10. Business Continuity

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

5.1.10.1.1. How the Contractor will replace staff that has been lost or is unavailable during or after a Business Interruption so that the Work is performed in accordance with the Contract.
5.1.10.1.2. 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.

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

5.1.10.1.3. How the Contractor will minimize the effects on Clients of any Business Interruption.

5.1.10.1.4. How the Contractor will communicate with the Department during the Business Interruption and points of contact within the Contractor’s organization the Department can contact in the event of a Business Interruption.

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

5.1.10.1.6. The time period it will take to transition all activities from the Contractor’s regular facilities to the back-up facilities after a Disaster.

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

5.1.10.2.1. DELIVERABLE: Business Continuity Plan

5.1.10.2.2. DUE: Within ten (10) Business days after the Effective Date

5.1.10.3. 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.

5.1.10.3.1. DELIVERABLE: Updated Business Continuity Plan

5.1.10.3.2. DUE: Semi-annually, by June 30th and December 31st of each year

5.1.10.4. 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, timelines and milestones contained in the implemented plan.

5.1.11. Intellectual Property Ownership for Projects Using Enhanced Federal Matching Funds

5.1.11.1. In addition to the intellectual property ownership rights in the Contract, the following subsections describe the intellectual property ownership requirements that the Contractor shall meet during the term of the Contract in relation to federal financial participation.
5.1.11.2. For any Work that uses enhanced 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, etc., designed, purchased, or developed by the Contractor and funded by the Department. The Contractor shall use contract funds to develop all necessary materials, programs, products, procedures, etc., and data and software to fulfill its obligations under the Contract. Department funding used in the development of these materials, programs, procedures, etc. shall be documented by the Contractor. The Department shall have all ownership rights in data and software, or modifications thereof and associated documentation and procedures designed and developed to produce any systems, programs reports and documentation and all other work products or documents created under the Contract. The Department shall have these ownership rights, regardless of whether the work product was developed by the Contractor or any Subcontractor for work product created in the performance of this Contract. The Department reserves, on behalf of itself, the Federal Department of Health and Human Services and its contractors, a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures. Such data and software includes, but is not limited to, the following:

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

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

5.1.11.2.3. All necessary data files.

5.1.11.2.4. User and operation manuals and other documentation.

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

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

5.1.12. Performance Reviews

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

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

5.1.12.3. The Contractor shall provide all information necessary for the Department to complete all performance reviews or evaluations, as determined by the Department, upon the Department's request. The Contractor shall provide this information regardless of whether the Department decides to work with the Contractor on any aspect of the performance review or evaluation.
5.1.12.4. The Department may conduct these performance reviews or evaluations at any point during the term of the Contract, or after termination of the Contract for any reason.

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

5.1.13. Renewal Options and Extensions

5.1.13.1. 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.

5.1.13.2. The Parties may amend the Contract to extend beyond five (5) years, in accordance with the Colorado Procurement Code and its implementing rules, in the event that the Department determines the extension is necessary to align the Contract with other Department contracts, to address State or Federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.

5.1.13.2.1. In the event that the Contract is extended beyond five (5) years, the annual maximum compensation for the Contract in any of those additional years shall not exceed the Contract maximum amount for the prior State Fiscal Year (SFY) plus the annual percent increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the Denver-Boulder-Greeley metropolitan area for the calendar year ending during that prior SFY. If the CPI-U is for some reason not available as specified in this subsection, the increase shall be equal to the percent increase in the CPI-U (U.S.) for the same period.

5.1.13.2.2. The limitation on the annual maximum compensation in this section 5.1.13.2. shall not include increases made specifically as compensation for additional work added to the Contract.

5.2. CONTRACTOR PERSONNEL

5.2.1. Personnel General Requirements

5.2.1.1. The Contractor shall provide qualified Key Personnel and Other Personnel as necessary to perform the Work throughout the term of the Contract. The Contractor shall provide the Department with a final list of individuals assigned to the Contract.

5.2.1.1.1. DELIVERABLE: Final list of names, resumes, and references of the individuals assigned to the Contract.

5.2.1.1.2. DUE: Within thirty (30) Business Days following the Effective Date.

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

5.2.1.3.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change

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

5.2.1.4. In the event that any individual filling a Key Personnel position leaves employment with the Contractor, the Contractor shall propose a replacement person to the Department. The replacement person shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department.

5.2.1.4.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) temporarily and/or permanently replacing anyone in a Key Personnel position who leaves employment with the Contractor

5.2.1.4.2. DUE: Within ten (10) Business Days following the Contractor's receipt of notice that the person is leaving employment.

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

5.2.1.5.1. DELIVERABLE: All current professional licensure and certification documentation as specified for Key Personnel or Other Personnel.

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

5.2.2. Personnel Availability

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

5.2.2.2. The Contractor shall ensure that operations personnel are accessible to the Department during Business Hours. Additionally, the Contractor shall ensure that an emergency contact is available, with reasonable prior notice, after 5:00 p.m. on Business Days and on weekends.

5.2.2.3. In the event that the Department determines that any Key Personnel or Other Personnel assigned by the Contractor to attend any meeting with the Department, or with any external entity or stakeholder, does not possess the knowledge or expertise necessary to participate effectively, the Contractor shall provide replacement personnel.
5.2.2.4. 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.

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

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

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

5.2.2.8. Meetings with the Department

5.2.2.8.1. At a minimum, the Contractor shall provide the appropriate Key Personnel and Other Personnel to attend all of the following meetings with the Department:

5.2.2.8.1.1. UM Contract Kick-Off Meeting

5.2.2.8.1.1.1. The UM Contract Kick-Off Meeting shall include all Key Personnel, executive project staff and/or any executive staff as determined by the Department.

5.2.2.8.1.1.2. The UM Contract Kick-Off Meeting shall be a one-time meeting held prior to the Operational Start Date as determined by the Department.

5.2.2.8.1.2. Semimonthly Contractor Meeting.

5.2.2.8.1.2.1. The Contractor shall lead a Semimonthly Contractor Meeting with the Department to discuss ongoing high level UM issues and overall work as defined in the Contract.

5.2.2.8.1.2.2. Attendees of the Semimonthly Contractor Status Meeting shall include the Project Lead, Medical Director, IT Lead and Other Personnel as determined by the Department.

5.2.2.8.1.2.3. The Project Lead shall attend the Semimonthly Contractor Meeting in person no less than once per month unless prior approval is obtained from the Department.

5.2.2.8.1.2.4. During the Semimonthly Contractor Meeting, the Contractor shall present its Utilization Review Monthly Report, and/or any quarterly reports available, as described in Section 5.12.4., highlighting the month’s review activities, outcomes and trends compared to previous periods and upcoming reviews.

5.2.2.8.1.3. Weekly Project Meeting
5.2.2.8.1.3.1. The Contractor shall lead a Weekly Project Meeting between the Project Lead and the Department’s primary designee to provide a detailed review and updates on the status of the Work and to resolve any issues.

5.2.2.8.1.3.2. The Contractor’s Project Lead shall lead all Weekly Project Meetings unless otherwise approved by the Department.

5.2.2.8.1.3.3. In the event that a backup designee attends the Weekly Project Meeting in place of the Department’s primary designee then the Contractor shall send a copy of the meeting minutes of that meeting to the Department’s primary designee.

5.2.2.8.1.4. Client Appeals Meeting

5.2.2.8.1.4.1. The Contractor shall participate in a Department led Client Appeal Status Meeting, at a minimum, on a weekly basis.

5.2.2.8.1.4.2. The Contractor shall be prepared to discuss the status of upcoming Client appeals and Client appeal strategies.

5.2.2.8.1.4.3. The Contractor’s Medical Director as well as pertinent staff shall attend all Client Appeal Status Meetings.

5.2.2.8.1.5. Information Technology (IT) Meeting

5.2.2.8.1.5.1. The Contractor shall lead an IT Meeting with the Department’s program and systems staff to discuss all technology interconnectivity, technical needs, the MMIS transition and to troubleshoot other IT needs.

5.2.2.8.1.5.2. The IT Meetings shall be held as follows:

5.2.2.8.1.5.2.1. The IT Meetings shall be held weekly until the Contractor has successfully tested with the Current MMIS.

5.2.2.8.1.5.2.2. During the implementation of the Future MMIS, IT Meetings shall be held weekly. The timeframe of the implementation of the Future MMIS shall be determined by the Department.

5.2.2.8.1.5.2.3. During all other times, IT Meetings shall be held as directed by the Department.

5.2.2.8.1.5.3. The Contractor’s Project Lead and Technical Lead shall attend all IT Meetings unless otherwise approved by the Department.

5.2.2.8.1.5.4. The Technical Lead shall attend the IT Meeting in person no less than once per month, unless prior approval is obtained from the Department, during all times during which weekly IT Meetings are held. At all times during which the IT Meetings are held less than weekly the Technical Lead shall attend IT Meetings in person as requested by the Department.

5.2.2.8.1.6. Monthly Regional Care Collaborative Organization (RCCO) Operations Meetings.

5.2.2.8.1.6.1. The Contractor’s Key Personnel shall attend and be prepared to participate in the Department lead Monthly RCCO Operations Meeting by telephone.
5.2.2.8.1.6.1.1. The Project Lead shall attend the Monthly RCCO Operations meeting in person no less than once per quarter unless prior approval is obtained from the Department.

5.2.2.8.2. The Contractor shall provide the Department with a proposed Department Meeting Schedule that includes the schedule for all meetings described in this section 5.2.2.8. that the Contractor is required to host. Once the Department has approved the Department Meeting Schedule, the Contractor shall host all meetings on that schedule unless the Department approves a change to the schedule. The Contractor shall update the Department Meeting Schedule to include any additional meetings as directed by the Department.

5.2.2.8.2.1. DELIVERABLE: Department Meeting Schedule.

5.2.2.8.2.2. DUE: Ninety (90) days prior to the Operational Start Date.

5.2.2.8.3. The Key Personnel and Other Personnel attending a meeting may attend meetings between the Contractor and the Department by telephone or video conference, unless the Department specifically requires the Contractor to be physically present at the meeting.

5.2.2.8.3.1. In the event that any Key Personnel and Other Personnel attend meetings by telephone or by video conference, then the Contractor shall provide all necessary telephone conference lines and host all video conferencing necessary for all attendees to participate, unless otherwise directed by the Department.

5.2.2.8.3.2. In the event that a meeting that the Contractor’s staff may attend by telephone will include discussion of any corrective action for the Contractor, a failure of the Contractor to meet any requirement of the Contract or any other Contract compliance issue, the Department may require the Contractor to have its Key Personnel and any other appropriate Other Personnel attend the meeting in person. The Department will give the Contractor advance notice if the Department requires the physical presence of any Key Personnel or Other Personnel at meetings.

5.2.2.8.4. For each meeting with the Department that the Contractor’s Key Personnel or Other Personnel leads, the Contractor shall do the following:

5.2.2.8.4.1. Create an agenda and provide status reports for each meeting.

5.2.2.8.4.2. Write and distribute meeting minutes within forty-eight (48) hours after each meeting.

5.2.3. Key Personnel

5.2.3.1. The Contractor shall designate people to hold the following Key Personnel positions:

5.2.3.1.1. Project Lead

5.2.3.1.1.1. The Project Lead shall have the following qualifications:

5.2.3.1.1.1.1. Minimum of a Master’s degree in nursing, public health, public policy and/or an equivalent healthcare related degree.
5.2.3.1.1.2. Minimum two (2) years’ experience managing UM, clinical care processes and outcomes, and clinical guidelines.

5.2.3.1.1.2. The Project Lead shall be responsible for all of the following:

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

5.2.3.1.1.2.2. Serving as Contractor’s primary point of contact for the Department.

5.2.3.1.1.2.3. Ensuring the completion of all Work in accordance with the Contract’s requirements. This includes, but is not limited to, ensuring the accuracy, timeliness and completeness of all work.

5.2.3.1.1.2.4. Overseeing all other Key Personnel and Other Personnel and ensuring proper staffing levels throughout the term of the Contract.

5.2.3.1.2. Technical Lead

5.2.3.1.2.1. The Technical Lead shall have the following qualifications:

5.2.3.1.2.1.1. Minimum of a bachelor’s degree in Information Systems or an equivalent degree or relevant specialty certifications.

5.2.3.1.2.1.2. A minimum of two (2) years’ experience managing IT systems.

5.2.3.1.2.1.3. A minimum of two (2) years’ experience analyzing health information data.

5.2.3.1.2.2. The Technical Lead shall:

5.2.3.1.2.2.1. Oversee all IT systems management and data analysis.

5.2.3.1.2.2.2. Oversee the Contractor’s web portals.

5.2.3.1.2.2.3. Function as a direct point of contact for the Department’s fiscal agent as well as the Department’s Claims and Operations division for issues related to Provider claims.

5.2.3.1.3. Medical Director

5.2.3.1.3.1. The Medical Director shall have the following qualifications:

5.2.3.1.3.1.1. Be a physician, licensed and registered in any state.

5.2.3.1.3.1.2. A minimum two years’ experience in state Medicaid programs with a focus on clinical care processes and outcomes, clinical guidelines, medical economics research, particularly the evaluation of medical utilization, population-based care practices and Provider billing practices.

5.2.3.1.3.2. The Medical Director shall:

5.2.3.1.3.2.1. Oversee all clinical and medical aspects of the UM Program in compliance with federal and state law and requirements of the Contract.
5.2.3.1.3.2.2. Attend by phone and function as a subject matter expert at all Client and Provider Appeals related to UM activities with an Administrative Law Judge presiding. With prior, written, approval of the Department, the Contractor may substitute a subject matter expert in place of the Medical Director at any hearing before an Administrative Law Judge.

5.2.3.1.3.2.2.1. In the event that the Medical Director is unable to attend an Administrative Law Judge hearing, the Contractor shall ensure that another physician attends in the Medical Director’s place with prior approval of the Department.

5.2.3.1.3.2.2.2. The Medical Director or approved subject matter expert shall review all documentation pertaining to the hearing prior to the hearing in order to be able to respond to issues relating to that documentation.

5.2.3.2. The Contractor shall not allow for any individual to fill more than one of the roles defined as Key Personnel.

5.2.3.3. The Contractor shall ensure that each Key Personnel is the equivalent of a full time employee.

5.2.4. Other Personnel

5.2.4.1. The Contractor shall provide sufficient Other Personnel to ensure the Completion of the Work. As a part of the Other Personnel provided by the Contractor, the Contractor shall ensure that there is a primary point of contact for the:

5.2.4.1.1. Client Over-Utilization Program

5.2.4.1.2. Regional Care Collaborative Organizations

5.2.4.1.3. Nurse Advice Line

5.2.4.2. The Contractor shall use its discretion to determine the number of Other Personnel necessary to perform the Work in accordance with the requirements of the Contract. In the event that the Department has determined that Contractor has not provided sufficient Other Personnel to perform the Work in accordance with the requirements of the Contract, the Contractor shall provide all additional Other Personnel necessary to perform the Work in accordance with the requirements of the Contract at no additional cost to the Department.

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

5.2.4.4. 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:

5.2.4.4.1. The Contractor shall not subcontract more than forty percent (40%) of the Work.

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

5.2.4.4.2.1. DELIVERABLE: Name of each Subcontractor and items on which each Subcontractor will work.
5.2.4.4.2.2. DUE: The later of thirty (30) days prior to the Subcontractor beginning work or the Effective Date.

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

5.2.4.5. Other Personnel may work on projects other than the Work outlined herein.

OFFEROR'S RESPONSE 3. Provide a detailed explanation of how the Offeror will provide sufficient personnel to perform the Work, including all of the following:

a. How the Offeror will provide Key Personnel that meets or exceeds the requirements contained in this RFP.

b. How the Offeror will provide and train all Other Personnel so that the Work is completed accurately and in a timely manner. Additionally, include a listing of the position titles for each position related to the Contract, the general responsibilities of that position, the number of individuals filling that position and the numbers of hours each week the position will be dedicated to the Work.

c. How the Offeror will ensure that the staffing plan will account for leaves of absences so that the Contractor’s staff is accessible and able to perform the work when assigned staff is on leave or otherwise unavailable.

d. How the Offeror will ensure appropriate coverage for meetings with the Department and for Provider and Client Appeals before an Administrative Law Judge when relevant personnel are out of the office.

e. A plan for how the Offeror will replace all Key Personnel and Other Personnel so that the transition between personnel does not impact the ability of the Contractor to complete the Work.

f. If the Offeror intends to use a Subcontractor, the Offeror shall provide a description of how the Offeror will use Subcontractors and the portions of the Work that will be completed by each Subcontractor. This description shall also include the anticipated positions provided by the Subcontractor and the roles of those positions, as well as a plan for how the Offeror will manage the Subcontractor and all Subcontractor personnel to ensure that the portions of the Work assigned to the Subcontractor will be completed accurately and in a timely manner.

g. Provide a detailed description of the Offeror’s internal organization structure for the UM Program, including delineated management structure. An organizational chart shall be included with the description, showing the number and types of employees.

5.3. UM ANALYSIS AND STRATEGY DEVELOPMENT

5.3.1. The Contractor shall analyze utilization patterns across all Medicaid benefits, identify areas of inappropriate utilization and identify opportunities for more effective UM strategies.
5.3.1.1. The Contractor shall maintain thorough, up-to-date knowledge of the range of UM strategies available and best practices.

5.3.1.2. The Contractor shall analyze and assess how the Contractor’s identified strategies could be used for Colorado Medicaid benefits and programs by conducting an analysis of the last thirty-six (36) months of claims and utilization data.

5.3.1.3. The Contractor shall maintain a pool of available clinical experts, under the guidance of the Contractor’s Medical Director, from a wide range of Provider types and specialties, to adequately address projects, issues and manual PAR reviews.

5.3.1.3.1. At the Department’s request the Contractor shall provide a list of available clinical experts it has access to.

5.3.1.3.1.1. DELIVERABLE: List of Clinical Experts.

5.3.1.3.1.2. DUE: Within five (5) Business Days following the Department’s request.

5.3.1.4. The Contractor shall identify the utilization trends that are most problematic and, if fixed, have the greatest potential to improve health outcomes or manage costs, or both.

5.3.1.5. In its analysis, the Contractor shall consider all state plan benefits and services as potential areas for focus.

5.3.2. UM Plan

5.3.2.1. The Contractor shall create and submit an Annual UM Plan to the Department for review and approval. The UM plan shall outline a five (5) year, comprehensive approach for Colorado Medicaid’s UM Program aimed at improving the health of Clients while containing costs.

5.3.2.2. The Contractor’s UM Plan shall include recommended strategies for improving performance in the following areas of the UM Program:

5.3.2.2.1. Type, frequency and number of prospective or retrospective reviews conducted by service type.

5.3.2.2.2. Expanding automated reviews to other service types.

5.3.2.2.3. Collaboration with Department stakeholders and programs including the Regional Care Collaborative Organizations.

5.3.2.2.4. Use of Technology to aide in effective administration of the program, including review automation, use of smart forms, electronic transmission of data, etc.

5.3.2.2.5. The Client Over-Utilization Program (COUP).

5.3.2.2.6. The Nurse Advice Line.

5.3.2.2.7. Special Projects.

5.3.2.2.8. Focused utilization studies.

5.3.2.2.9. Provider education and/or incentive programs.

5.3.2.2.10. Other areas as appropriate.
5.3.2.3. The Contractor shall base the UM Plan’s recommended strategies on the analysis of Department claims data files, national best practices in the industry and the goals and objectives of the Department’s programs and initiatives.

5.3.2.4. The Contractor’s UM Plan shall include the following for each recommended strategy:

5.3.2.4.1. A description of the strategy, including benefits and Providers that will be impacted.

5.3.2.4.2. Rationale supporting the strategy, including benchmarks for improved performance.

5.3.2.4.3. Timeline and high-level work plan for implementation, including assignment of staff resources.

5.3.2.4.4. Prioritization relative to other recommended strategies.

5.3.2.5. The Contractor shall not implement recommended strategies until approved by the Department.

5.3.2.6. The Contractor shall submit the Annual UM Plan to the Department each State Fiscal Year.

5.3.2.6.1. DELIVERABLE: Initial UM Plan.

5.3.2.6.2. DUE: Six (6) months after the Operational Start Date.

5.3.2.6.3. DELIVERABLE: Annual UM Plan.

5.3.2.6.4. DUE: Annually by June 15th for the plan covering the next State Fiscal Year

5.3.2.7. Once the Department has approved an Annual UM Plan for a State Fiscal Year, the Contractor shall implement each strategy, activity, review and any other item in the approved plan. The Contractor shall not begin any strategy, activity, review or any other item in an Annual UM Plan prior to the Department’s approval of that plan.

5.3.2.7.1. The Contractor shall prioritize all strategies, activities, reviews and any other items in an Annual UM Plan in accordance with the prioritization included in that plan, unless otherwise directed by the Department.

5.3.2.8. The Contractor shall update each Annual UM Plan within six (6) months after the delivery of the Annual UM Plan.

5.3.2.8.1. This update shall include, at a minimum, all of the following:

5.3.2.8.1.1. Any changes in circumstances or priorities.

5.3.2.8.1.2. Newly identified opportunities and suggested UM activities.

5.3.2.8.1.3. Activities the Contractor is working on and the status of each of those activities.

5.3.2.8.1.4. Progress toward the Annual UM Plan objectives, using resources such as claims data to demonstrate progress. Progress may be described in terms of cost avoidance, return on investment, or utilization rates.

5.3.2.8.2. The Contractor shall deliver the Updated Annual UM Plan to the Department for review and approval.

5.3.2.8.2.1. DELIVERABLE: Updated Annual UM Plan.
5.3.2.8.2.2. DUE: Annually, no later than December 15th of the State Fiscal Year the original Annual UM Plan covered.

5.3.2.8.3. The Contractor shall not implement any Updated Annual UM Plan until the Department has approved that plan.

5.3.3. Collaboration with Other Organizations and Entities

5.3.3.1. The Contractor shall collaborate and communicate with Department personnel, vendors and partners to maximize the impact of the UM Program on improving Client health, maintaining costs and advancing the goals and objectives of the Department’s key programs and initiatives.

5.3.3.2. The Contractor shall collaborate/communicate with others in a way that fosters meaningful dialog, exchange of information and the generation of ideas aimed at improving Department programs and outcomes. At a minimum, the Contractor’s collaborative efforts shall include:

5.3.3.2.1. Establishing points of contact with other vendors and for key initiatives and standard business processes both within and outside the Department.

5.3.3.2.2. Sharing data with other programs and contractors.

5.3.3.2.3. Participating in ongoing and ad hoc meetings, community forums and program-related advisory committee structures, including, but not limited to the ACC Program Improvement Advisory Committees and the Benefit Collaborative process.

5.3.3.2.4. Developing and disseminating UM Program training and supportive materials for providers, contractors and other Department stakeholders.

5.3.3.2.5. During the start-up phase of the Contract, the Contractor shall establish a point of contact with each RCCO in the ACC program, individual PCMPs as appropriate and the SDAC. The Contractor shall create and maintain a Point of Contact List documenting who the point of contact is with each entity described in this section.

5.3.3.2.5.1. DELIVERABLE: Point of Contact List

5.3.3.2.5.2. DUE: Within five (5) days of the Operational Start Date

5.3.3.3. Collaboration Plan

5.3.3.3.1. The Contractor shall develop an Initial and a Final Collaboration Plan.

5.3.3.3.1.1. The Initial and Final Collaboration Plan shall include, but not be limited to, the Contractors approach to:

5.3.3.3.1.1.1. Improving Client health and maintaining costs.

5.3.3.3.1.1.2. Sharing data with other programs and contractors.

5.3.3.3.1.1.3. Participating in ongoing and ad hoc meetings, community forums and program-related advisory committee structures.

5.3.3.3.1.1.4. Developing and disseminating UM Program training and supportive materials for providers, contractors and other Department stakeholders.
5.3.3.3.1.2.  The Contractor shall deliver the Initial Collaboration Plan to the Department for review and approval.

5.3.3.3.1.2.1.  DELIVERABLE: Initial Collaboration Plan

5.3.3.3.1.2.2.  DUE: No later than the Operational Start Date

5.3.3.3.1.3.  Once the Contractor and the Department have determined the effectiveness of the Initial Collaboration Plan, the Contractor shall update the Initial Collaboration Plan to include changes necessary to improve the effectiveness of that plan. The Contractor shall deliver the updated plan in the form of a Final Collaboration Plan to the Department for review and approval.

5.3.3.3.1.3.1.  DELIVERABLE: Final Collaboration Plan

5.3.3.3.1.3.2.  DUE: Within six (6) months following the Operational Start Date

5.3.3.3.1.4.  The Contractor shall update and submit an Annual Collaboration Plan annually to include any necessary changes to increase the effectiveness of the plan.

5.3.3.3.1.4.1.  DELIVERABLE: Annual Collaboration Plan

5.3.3.3.1.4.2.  DUE: Annually by July 31st

**OFFEROR'S RESPONSE 4.**  In regard to Section 5.3.3., provide an explanation of how the Contractor will collaborate and communicate with Department Personnel, Vendors and partners to maximize the impact of the UM Program. Describe the type and frequency of UM Training for Providers, Contractors and other stakeholders that the Offeror will provide. Explain how the Offeror will detect problem areas that require trainings, outreach or data sharing.

5.4.  UTILIZATION REVIEW

5.4.1.  Prospective Review General Requirements

5.4.1.1.  The Contractor shall conduct Prospective Reviews to ensure that services provided to Medicaid Clients are medically necessary, appropriate and provided at the most economic site of care.

5.4.1.1.1.  The Contractor shall conduct all Prospective Reviews in alignment with the Department’s current policies, benefits and unit limitations.

5.4.1.2.  The Contractor shall ensure that:

5.4.1.2.1.  Reviews are conducted by qualified licensed health professionals.

5.4.1.2.2.  Reviews are conducted in compliance with all federal and state statutes and regulations.

5.4.1.3.  The Department may, in limited circumstances, examine any review and override a decision made by the Contractor in order to comply with Department policy and/or federal or state statutes and regulations.

5.4.2.  Review criteria
5.4.2.1. The Contractor shall utilize Department approved nationally recognized evidence-based PAR review criteria for all services such as Milliman or InterQual.

5.4.2.2. The Contractor shall incur all costs for program licensing related to evidence-based PAR criteria such as Milliman or InterQual.

5.4.2.3. For any service that does not have nationally recognized criteria, the Contractor shall develop criteria. In the event that the Contractor develops PAR criteria, the Contractor shall deliver those criteria to the Department for review and approval. The Contractor shall not use any PAR criteria it developed prior to the Department’s approval of that criteria.

5.4.2.3.1. DELIVERABLE: Contractor Developed PAR Criteria

5.4.2.3.2. DUE: Prior to the Contractor’s use of that criteria.

5.4.2.4. The Contractor shall provide the Department with review criteria for any PARs upon request.

5.4.2.4.1. DELIVERABLE: Review Criteria

5.4.2.4.2. DUE: Upon request by the Department

5.4.2.5. The Contractor shall develop modified review criteria as necessary to accommodate the unique needs and federal requirements for children under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), pregnant women and other special Medicaid populations.

5.4.2.6. The Contractor shall modify review criteria to accommodate the unique needs of the Department’s programs as identified in coverage policies and procedures.

5.4.2.7. The Contractor shall modify DME review criteria to ensure that an evaluation is completed to determine whether a less costly, medically appropriate alternative exists.

5.4.2.8. The Contractor shall update review criteria to reflect best practices and to mitigate concerning trends in utilization on at least an annual basis.

5.4.3. PAR Reviews

5.4.3.1. The Contractor shall conduct a manual or automated prospective review for all services and supplies currently requiring a prior authorization and for any service and supply requested by the Department including, but not limited to, out of state services and Office Administered Medications.

5.4.3.2. The Contractor shall add or remove review types based on recommendations approved in the UM Plan or as directed by the Department. Appendix P, 3 Year Par History, outlines recent PAR levels.

5.4.3.3. PAR Turnaround Time

5.4.3.3.1. The Contractor shall complete all prospective reviews in four (4) days or less.

5.4.3.3.2. The Contractor shall complete all Expedited prospective reviews within forty-eight (48) hours.

5.4.3.4. Automated Reviews
5.4.3.4.1. The Contractor shall perform Automated Reviews for PARs that can be completed using algorithm-based utilization review software and can provide real-time determinations of approval or denial.

5.4.3.4.1.1. The Contractor shall not implement any expansion of Automated PAR Review or change a Manual Review to an Automated Review until approved by the Department.

5.4.3.5. Manual Reviews

5.4.3.5.1. The Contractor shall complete a Manual Review for services that do not have an Automated Review process or when the Department requests conversion of an Automated Review to a Manual Review.

5.4.3.5.2. The Contractor shall perform Manual Reviews for the following:

5.4.3.5.2.1. Closed Codes for Clients age twenty (20) and under where services may meet medical necessity under EPSDT.

5.4.3.5.2.2. Out of state services including inpatient stays.

5.4.3.5.2.3. Any PAR completed using the following tools:

5.4.3.5.2.3.1. Pediatric Assessment Tool (PAT): see Appendix F.

5.4.3.5.2.3.2. Personal Care Assessment Tool (PCAT): currently under development, see Appendix G.

5.4.3.5.2.3.3. Private Duty Nursing (PDN) Tool: an updated PDN tool is currently under development, for current tool see Appendix J.

5.4.3.5.3. When performing Manual Reviews involving the assessment tools identified above, the Contractor shall ensure there is no duplication of services. The Contractor shall perform a side by side comparison of completed assessment tools for related or companion services.

5.4.3.5.4. For all out of state inpatient stays the Contractor shall complete a manual review and submit its recommendation for approval or denial to the Department. The Department will review the recommendation and provide the Contractor with a final decision. The Contractor shall issue an approval or denial as directed by the Department.

5.4.3.5.5. The Contractor shall create and draft a Manual PAR Review Policy and Procedure Report outlining the Contractor’s manual review process.

5.4.3.5.5.1. All Manual Reviews shall be conducted in accordance with the most recently approved version of the Contractor’s Manual PAR Review Policies and Procedures Report.

5.4.3.5.5.2. The Contractor shall ensure that all Manual Reviews are completed by qualified licensed professionals.

5.4.3.5.5.2.1. The Medical Director shall review all denied or partially denied Manually Reviewed PARs and make the final denial determination.

5.4.3.5.5.3. DELIVERABLE: Manual PAR Review Policies and Procedures Report.
5.4.3.5.4. DUE: Thirty (30) days prior to the Operational Start Date.

5.4.3.5.6. The Contractor shall update the Manual PAR Review Policies and Procedures Report annually.

5.4.3.5.6.1. The Contractor shall submit an updated Manual Review Procedure to the Department annually, when changes are made to the process, and upon request by the Department.

5.4.3.5.6.1.1. DELIVERABLE: Updated Manual Review Policies and Procedures.

5.4.3.5.6.1.2. DUE: Within fifteen (15) days of changes being made or upon Department request.

5.4.3.6. Provider Customer Service Line

5.4.3.6.1. The Contractor shall operate a toll-free Provider Customer Service Line dedicated to Medicaid Providers.

5.4.3.6.2. The Contractor shall ensure that the Provider Customer Service Line allows Medicaid Providers to:

5.4.3.6.2.1. Submit PARs.

5.4.3.6.2.2. Direct inquiries to the Contractor including, but not limited to:

5.4.3.6.2.2.1. PAR submissions.

5.4.3.6.2.2.2. PAR determination statuses.

5.4.3.6.2.2.3. Reconsiderations and/or Peer-To-Peer Reviews.

5.4.3.6.3. The Contractor shall ensure that the Provider Customer Service Line:

5.4.3.6.3.1. Includes a phone tree activated by touch.

5.4.3.6.3.2. Is staffed on all Business Days during Business Hours.

5.4.3.6.3.3. Has a voice mailbox or equivalent system/technology to handle after hours inquiries.

5.4.3.6.3.4. Includes an outgoing message stating that after hours calls will be returned no later than close of business the next Business Day.

5.4.3.6.4. The Contractor shall:

5.4.3.6.4.1. Return all voice mailbox messages by close of business on the Business Day following the day the message is recorded.

5.4.3.6.4.2. Transfer the Provider Customer Service line phone number to the Department or another Department contractor at the end of the Contract Term.

5.4.3.6.4.3. Keep a log of all calls.

5.4.3.6.4.3.1. The Contractor shall ensure that the log can be searched by Provider, date of the call, Client name or issue.

5.4.3.6.4.3.1.1. DELIVERABLE: Provider Call Log.

5.4.3.6.4.3.1.2. DUE: Within one (1) Business Day of the Department’s request.
5.4.3.7. Telephonic, Facsimile and Paper PAR Processing
5.4.3.7.1. The Contractor shall process PARs by telephone, facsimile or paper in the following circumstances:

5.4.3.7.1.1. When the UM Provider Web Portal is not functioning properly.
5.4.3.7.1.2. For out-of-state, or out-of-area inpatient stays when the Client is not in their home community and is seeking care with an out of state specialist and requires an authorization.
5.4.3.7.1.3. For Providers who specifically request telephonic, facsimile or paper PAR submission services and who submit an average of five (5) or fewer PARs per month including out of state Providers.
5.4.3.7.1.4. For Providers who are visually impaired.
5.4.3.7.1.5. At the request of the Department.

5.4.4. Prospective Review Denials
5.4.4.1. The Contractor shall offer Provider Peer-To-Peer and Provider Reconsideration options for any PAR that has been denied or partially denied.
5.4.4.2. Following a Provider Peer-To-Peer or Provider Reconsideration review the Contractor shall make a determination upholding, modifying, or reversing the denial or partial denial for requested services.
5.4.4.3. Following the Reconsideration or Peer-To-Peer Review, the Contractor shall complete the review and notify the parties of a decision within forty-eight (48) hours (excluding non-Business Days) for an Expedited request, and four (4) Business Days following a standard Reconsideration or Peer-To-Peer review.

5.4.4.4. Provider Peer-To-Peer
5.4.4.4.1. The Contractor shall ensure that all Peer-To-Peers are completed by a physician with the same clinical expertise and background as the rendering Provider requesting the Peer-to-Peer.
5.4.4.4.2. The Contractor shall ensure the Provider handling each Peer-To-Peer is the same Provider who performed the initial PAR review.

5.4.4.5. The Contractor shall conduct a Peer-To-Peer for any Provider who is dissatisfied with the Contractor’s decision on any type of review and who has requested the Peer-To-Peer within five (5) calendar days after a denial or partial denial decision.

5.4.4.6. The Contractor shall review any additional clinical information during the Peer-To-Peer review submitted for review, if submitted within the first five (5) calendar days following a denial decision.

5.4.4.7. Provider Reconsiderations
5.4.4.7.1. The Contractor shall examine all relevant evidence in the record regarding the services in question and any new documentation submitted by the Provider within ten (10) calendar days following a denial or partial denial.
5.4.4.7.2. The Contractor shall ensure that the Physician reviewer handling the Reconsideration is a different Provider than the one that performed the initial review.

5.4.4.7.2.1. The Physician reviewer handling the Reconsideration shall have the same clinical expertise and background as the rendering Provider.

5.4.4.7.3. The Contractor shall conduct a Reconsideration for the following Providers:

5.4.4.7.3.1. Any provider who is dissatisfied with the Contractor’s decision on any type of review and who has requested the reconsideration within ten (10) calendar days of the denial or partial denial decision.

5.4.4.7.3.2. Any Provider who submits additional clinical information for review within the first ten (10) calendar days following a denial or reduction decision.

5.4.4.8. Provider Peer-To-Peer and Reconsideration Denial Protocols

5.4.4.8.1. The Contractor shall establish and implement Provider Peer-To-Peer and Reconsideration protocols, that are compatible with the Department’s MMIS, for all types of reviews in which the decision is:

5.4.4.8.1.1. A denial or partial denial of any service or item based on medical necessity or current Department Benefits Collaborative policies.

5.4.4.8.1.2. An adjustment in payments due to Retrospective Reviews results.

5.4.4.8.1.3. A technical denial, such as a denial of services for reasons other than medical necessity or benefit coverage policy.

5.4.4.8.2. The Contractor shall establish written protocols for managing Provider Peer-To-Peer and Reconsideration requests.

5.4.4.8.2.1. The protocol shall include, but is not limited to, the following:

5.4.4.8.2.1.1. Process for reviewing the request for Peer-to-Peer and/or Reconsiderations and all relevant records.

5.4.4.8.2.1.2. Process for educating Providers about the Peer-To-Peer and Reconsideration process and that a Client may appeal at any point during either the Reconsideration or the Peer-To-peer process.

5.4.4.8.2.1.3. Process for referring all Reconsideration and Peer-to-Peer requests to a reviewer with the same clinical expertise and background as the rendering Provider.

5.4.4.8.2.1.4. Process for ensuring that all Peer-to-Peer and Reconsideration requests for any Client age twenty (20) and under meets the federal definition for medical necessity and that the second review can be used in an administrative appeal and state fair hearing process to show it meets federal regulations for EPSDT.

5.4.4.8.2.1.5. Process for completing and documenting the Reconsideration or the Peer-To-Peer and notifying the parties of a decision within forty-eight (48) hours (excluding non-Business Days) following an Expedited review, and four (4) Business Days following a standard Reconsideration or Peer-To-Peer review.
5.4.4.8.2.1.5.1. The Contractor shall record and report all Reconsiderations and Peer-To-Peer reviews for the analysis of UM Practices to the Department’s fiscal agent.

5.4.4.8.2.1.6. Process for notifying the Provider of the Reconsideration or Peer-to-Peer decision. The Contractor shall obtain Department approval for all written notification templates, which shall include:

5.4.4.8.2.1.6.1. A brief statement of the Contractor’s authority and responsibility to review.
5.4.4.8.2.1.6.2. Date of the notice.
5.4.4.8.2.1.6.3. Service(s) and date(s) of service denied or reduced.
5.4.4.8.2.1.6.4. Determination and the reason for determination.
5.4.4.8.2.1.6.5. Client’s right to file an administrative appeal.
5.4.4.8.2.1.7. A template for a Peer-to-Peer and Reconsideration Decision Notification.
5.4.4.8.2.1.8. A process to ensure that a Client can request an administrative hearing at any point during the Reconsideration or the Peer-To-Peer process.
5.4.4.8.2.2. The Contractor shall deliver the written Peer-to-Peer and Reconsideration Appeal Protocols to the Department for review and approval.

5.4.4.8.2.2.1. DELIVERABLE: Peer-To-Peer and Reconsideration Appeal Protocols.
5.4.4.8.2.2.2. DUE: Thirty (30) days prior to the Operational Start Date

5.4.4.8.3. The Contractor shall ensure that Clients and Providers are aware of a Client’s right to request an administrative hearing at any time including during the Peer-To-Peer and Reconsideration processes.

5.4.4.8.4. In the event that a Client files a Client Appeal, the Contractor shall ensure that any Peer-to-Peer or Reconsideration requested by a Provider is completed within the appropriate timeframe.

5.4.4.9. Client Appeals

5.4.4.9.1. A Colorado Medicaid Client has the right to file a Client appeal of a denial or partial denial of a Prospective Review per 10 CCR 2505-10. In the event that a Client appeals a Prospective Review denial or partial denial, the Contractor shall support the Department in the Client appeal by doing all of the following:

5.4.4.9.1.1. Providing the Department with all relevant information pertaining to the Client appeal within two (2) Business Days of the Department’s request.
5.4.4.9.1.1.1. Items requested may include but are not limited to copies of Client medical records, call logs and all applicable correspondence.
5.4.4.9.1.2. Providing the Department with review evidence and testimony at Client appeals, as requested by the Department.
5.4.4.9.1.3. Participating in all Client Appeal Status conference calls to discuss Client appeals, as determined by the Department.
5.4.4.9.2. In the event that a Client files a Client Appeal, the Contractor shall ensure that any Peer-to-Peer or Reconsideration requested by a Provider is completed within the appropriate timeframe. This may require that the Contractor complete a Peer-to-Peer, Client Appeal and Reconsideration simultaneously.

5.4.5.  Retrospective Reviews

5.4.5.1. The contractor shall complete, at a maximum, five hundred (500) Retrospective Reviews each quarter.

5.4.5.2. The Contractor shall not perform Retrospective Reviews on Managed Care Clients.

5.4.5.3. The Contractor shall obtain the Department’s approval prior to initiating any Retrospective Reviews requested by the Department or proposed by the Contractor in the Department-approved UM Plan.

5.4.5.4. Retrospective Reviews shall include, but are not limited to, the following review categories:

5.4.5.4.1. Admissions.

5.4.5.4.2. Readmissions.

5.4.5.4.3. Short stays.

5.4.5.4.4. All Patient Refined Diagnosis Related Groups (APR-DRG).

5.4.5.4.5. High cost claims.

5.4.5.4.6. Hospital claims.

5.4.5.4.7. Quality of care reviews.

5.4.5.5. Medical Necessity

5.4.5.5.1. The Contractor shall analyze and review Medicaid claims utilizing Diagnosis-Related Group (DRG) methodology, to determine possible overpayments.

5.4.5.5.2. The Contractor shall identify overpayments resulting from the billing of non-medically necessary services. Medical Necessity Determinations include, but are not limited to, treatments that are:

5.4.5.5.2.1. Provided in accordance with generally accepted standards of medical practice in the United States.

5.4.5.5.2.2. Clinically appropriate in terms of type, frequency, extent, site and duration.

5.4.5.5.2.3. Not primarily for the economic benefit of the Provider or for the convenience of the Client, caretaker or Provider.

5.4.5.5.2.4. Performed in a cost effective and most appropriate setting required by the Client's condition.

5.4.5.5.2.5. Not experimental or investigational.

5.4.5.6. Serious Reportable Event Reviews
5.4.5.6.1. The Contractor shall review claims upon identification of a serious reportable event or upon the Department’s request to determine whether there is an overpayment to the hospital for any such event.

5.4.5.6.2. The Contractor shall notify the Department’s MMIS for full payment recovery if a claim is associated with any of the following three (3) Serious Reportable Events:

5.4.5.6.2.1. Surgery performed on the wrong body part.
5.4.5.6.2.2. Surgery performed on the wrong patient.
5.4.5.6.2.3. Wrong surgical procedure on a patient.

5.4.5.7. Quality of Care Issues

5.4.5.7.1. The Contractor shall notify the Department when a quality of care issue is identified and shall submit a Quality of Care Plan to the Department for review and approval. The Quality of Care Plan shall include, but not be limited to:

5.4.5.7.1.1. Issues identified.
5.4.5.7.1.2. Steps Provider needs to complete to resolve each issue.
5.4.5.7.1.3. Timeline Provider has to complete the resolution.
5.4.5.7.1.3.1. DELIVERABLE: Quality of Care Plan
5.4.5.7.1.3.2. DUE: Within seven (7) days of identifying the issue

5.4.5.7.2. The Contractor shall work directly with Providers to help Providers complete the Quality of Care Plan.

5.4.5.7.3. The Contractor shall follow up with the Provider to ensure that the Provider has completed the Quality of Care Plan and resolved all identified issues.

5.4.5.7.4. The Contractor shall complete and submit a Follow-up Report to the Department. The Follow-up Report shall include a summary of the Contractor’s follow up with the Provider and a confirmation that all identified issues have been resolved.

5.4.5.7.4.1. DELIVERABLE: Follow-up Report
5.4.5.7.4.2. DUE: Within seven (7) days of the Contractor’s confirmation that the Provider has resolved all identified issues

5.4.5.8. Fraud and False Claims

5.4.5.8.1. The Contractor shall notify the Department within twenty-four (24) hours when it identifies or suspects Provider fraud or false claims at any stage of the review process.

5.4.5.8.2. Suspected fraud includes identification of intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to the individual or some other person.

5.4.5.8.3. Upon discovery of suspected fraud or other findings described above, the Contractor shall submit written documentation to the Department within two (2) Business Days.

5.4.5.8.3.1. The written report to the Department shall include:
5.4.5.8.3.1.1. All details of the findings and concerns, including a chronology of Contractor’s actions that resulted in the reports.

5.4.5.8.3.1.2. Any affected claims that have been discovered.

5.4.5.8.3.1.3. Any claims data associated with its report.

5.4.5.8.3.2. The Contractor shall create and submit a Fraud/False Claims Report template to the Department for review and approval. The Fraud/False Claims Report shall include, but not be limited to:

5.4.5.8.3.2.1. Provider name and ID.

5.4.5.8.3.2.2. Transaction Control Numbers (TCNs).

5.4.5.8.3.2.3. Reason for suspected fraud or abuse.

5.4.5.8.3.2.3.1. DELIVERABLE: Fraud/False Claims Report Template

5.4.5.8.3.2.3.2. DUE: By the Operational Start Date

5.4.5.8.3.2.4. DELIVERABLE: Fraud/False Claims Report

5.4.5.8.3.2.5. DUE: Within two (2) Business Days of the discovery

5.4.5.8.4. The Contractor shall not take any kind of recovery action, impose any sanction, suspend payments, suspend or terminate a Provider or initiate any kind of activity against a Provider where fraud is suspected.

5.4.5.8.5. The Contractor shall not take any action that may interfere with an investigation of possible fraud by the Department, the Medicaid Fraud Control Unit (MFCU), or any other law enforcement entity.

5.4.5.8.5.1. The Contractor shall assist the Department, the MFCU or any other law enforcement entity as requested with any investigation and any civil or criminal cases by the State or Federal governments, including false claims act cases.

5.4.5.8.6. The Contractor shall suspend all review activities or actions related to any Provider that the Contractor suspects is involved in fraudulent activity until notified by the Department to resume.

5.4.5.8.7. Upon the Department’s request, the Contractor shall temporarily suspend all review activities or actions related to any Provider.

5.4.5.9. Retrospective Review Process

5.4.5.9.1. The Contractor shall identify claims for each quarter’s review that are proposed by the Department or by the Contractor per the Department-approved UM Plan.

5.4.5.9.1.1. All retrospective review identifiers, and detailed TCNs to be reviewed, shall be forwarded to and approved by the Department prior to the Client’s record being requested.

5.4.5.9.2. The Contractor shall submit a Medical Record Request (MRR) to a Provider at least ten (10) Business Days prior to the commencement of the review.

5.4.5.9.2.1. The Contractor shall comply with the requirements set forth in 10 CCR 2505-10, Section 8.076.2 for all MRRs.
5.4.5.9.2.2. The Contractor shall create a MRR Template and submit it to the Department for review and approval. The MRR Template shall include, but not be limited to:

5.4.5.9.2.2.1. The requested records.
5.4.5.9.2.2.2. The option of delivering, via secure transmission, a reproduction of the records in each request.
5.4.5.9.2.2.3. A brief statement of the Contractor’s authority and responsibility to review.
5.4.5.9.2.2.4. Name, address and phone number of the Contractor’s specific contact whom Providers may direct questions or requests for additional information to.

5.4.5.9.2.2.4.1. DELIVERABLE: MRR Template
5.4.5.9.2.2.4.2. DUE: By the Operational Start Date

5.4.5.9.2.3. The Contractor shall provide copies of each MRR letter to the Department within twenty-four (24) hours of the letters being sent to the Provider.

5.4.5.9.2.3.1. DELIVERABLE: Provider MRR Letter
5.4.5.9.2.3.2. DUE: Within twenty-four (24) hours of the letters being sent to the Provider

5.4.5.9.2.4. The Contractor shall send a second MRR letter if the Provider fails to submit records within thirty (30) days of the first request, or fails to contact the Contractor to request an extension.

5.4.5.9.2.5. The Contractor shall notify the Department of all MRRs that are not responded to after two (2) requests.

5.4.5.9.3. The Contractor shall determine medical necessity after reviewing the provided medical records and documentation.

5.4.5.10. Review Notification

5.4.5.10.1. The Contractor shall notify Providers of all review findings within two (2) Business Days of completing the review. The Contractor shall communicate directly with the Provider during the review process to ensure receipt of all proper documentation.

5.4.5.10.1.1. The Contractor shall notify Providers even if no findings are made.

5.4.5.10.2. The Contractor shall send the Provider a written Review and Demand Notification of the findings, which shall including the following information:

5.4.5.10.2.1. A brief statement of the Contractor’s authority and responsibility to review.
5.4.5.10.2.2. Date of the notice.
5.4.5.10.2.3. Service(s) and date(s) of service denied.
5.4.5.10.2.4. The reason for the determination.
5.4.5.10.2.5. A statement informing the hospital of the right to submit additional information, and the timeframe in which to submit it.

5.4.5.10.2.6. Name, address and phone number of the Contractor’s specific contact whom Providers may direct questions or requests for additional information to.
5.4.5.10.2.7. A statement informing the hospital of its right to a Reconsideration or Appeal with specific instructions as set forth in 10 CCR 2505-10, Section 8.050.

5.4.5.10.2.8. The amount the Department will recover from the Provider.

5.4.5.10.3. The Contractor shall create a Provider Retrospective Review Notification Template and submit it to the Department for review and approval.

5.4.5.10.3.1. DELIVERABLE: Provider Retrospective Review Notification Template.

5.4.5.10.3.2. DUE: The later of the Effective Date or four (4) weeks prior to Operational Start Date.

5.4.5.10.4. The Contractor shall submit all review determinations to the Department, including an itemized report of the findings and copies of the letters sent to Providers. The Contractor shall share and transfer Client records, PAR information and/or Retrospective Review findings with the Department’s Program Integrity program, Department staff or other Department vendors at the request of the Department.

5.4.5.10.5. For any type of claims reviews which may result in an adjustment to the amount paid to a Provider, the Contractor shall not review any claims that have already been audited or that are currently being audited by another entity.

5.4.5.11. Provider Reconsideration and Appeals

5.4.5.11.1. The Contractor shall examine all relevant evidence in the record regarding the services in question and any new documentation submitted by the Provider within ten (10) calendar days following receipt of Retrospective Review Notification letter.

5.4.5.11.2. The Contractor shall ensure that the Physician reviewer handling the Reconsideration is the same Provider that handled the initial review.

5.4.5.11.2.1. If the same Physician that handled the initial Retrospective review is not available, the Physician reviewer handling the Reconsideration shall have the same clinical expertise and background as the rendering Provider.

5.4.5.11.3. The Contractor shall conduct a Reconsideration for the following Providers:

5.4.5.11.3.1. Any provider who is dissatisfied with the Contractor’s decision on any type of review and who has requested the Reconsideration and submitted the additional clinical documentation within ten (10) calendar days following the notification of the decision.

5.4.5.11.4. The Contractor shall make a final determination within seven (7) Business Days following receipt of additional documentation.

5.4.5.11.5. The Contractor shall work with the Attorney General’s Office and the Department as required for Retrospective Provider Appeals.

5.4.5.11.5.1. The Contractor shall provide the Department with all relevant information pertaining to the Provider Appeal within two (2) Business Days of the Department’s request.

5.4.5.11.5.1.1. Items requested may include but are not limited to copies of Client medical records, call logs and all applicable correspondence.
5.4.5.11.5.2. Providing the Department with review evidence and testimony at Provider Appeals, as requested by the Department.

5.4.5.11.5.3. Participating in all Provider Appeal Status conference calls to discuss Provider Appeals, as determined by the Department.

5.4.6. Healthcare Common Procedure Coding System (HCPCS) Review

5.4.6.1. The Contractor shall complete a review, on an annual basis, of all Level I and Level II Healthcare Common Procedure Coding System (HCPCS) codes released to state agencies by the Centers for Medicare and Medicaid Services (CMS) prior to their being publically released.

5.4.6.2. To complete the review, the Contractor shall review all ‘added’ or ‘deleted’ codes in the HCPCS coding set.

5.4.6.2.1. For all ‘added codes’, using a spreadsheet or document provided by the Department, the Contractor shall make recommendations regarding, but not limited to:

5.4.6.2.1.1. Whether the code should be covered by Colorado Medicaid.

5.4.6.2.1.2. Whether a PAR should be required.

5.4.6.2.1.3. Appropriate Provider types.

5.4.6.2.1.4. Appropriate place of service.

5.4.6.2.1.5. Age or other restrictions.

5.4.6.2.1.6. Appropriate payment rate for codes recommended for coverage by Colorado Medicaid but not covered by Medicare of private insurance.

5.4.6.2.2. For all ‘deleted’ codes, using a spreadsheet provided by the Department, the Contractor shall make recommendations about whether there is another existing or ‘added’ code that should be used in place of the ‘deleted’ code.

5.4.6.3. The Contractor shall complete its review within three (3) weeks of receiving the code set from the Department.

5.4.6.3.1. DELIVERABLE: HCPCS Review and Spreadsheets

5.4.6.3.2. DUE: Within three (3) weeks of receiving the coding set from the Department

5.5. TECHNOLOGY AND SYSTEM INTERFACE

5.5.1. UM Provider Website

5.5.1.1. The Contractor shall establish and maintain a Provider Website for the UM Program.

5.5.1.2. The Contractor shall be responsible for all costs in developing and maintaining the UM Provider Website.

5.5.1.3. The Contractor shall draft, revise and maintain all site content.

5.5.1.3.1. The Contractor shall audit the site for accuracy and ensure all links are active at a minimum on a monthly basis and shall remove and/or update information during the audit.

5.5.1.4. The UM Provider Website shall contain, at a minimum:
5.5.1.4.1. An overview of the Colorado Medicaid program including but not limited to:
5.5.1.4.1.1. The ACC program including individual RCCO contact information.
5.5.1.4.1.2. The BHO program including individual BHO contact information.
5.5.1.4.1.3. The Dental program.
5.5.1.4.1.4. Other Department resources.
5.5.1.4.2. A Description of the UM Program including but not limited to:
5.5.1.4.3. The NAL
5.5.1.4.4. COUP
5.5.1.4.5. A direct link to the UM Provider Web Portal including but limited to:
5.5.1.4.6. Instructions on how to enroll and obtain log in IDs and passwords.
5.5.1.4.7. Training for Providers
5.5.1.4.8. Information on the Provider Customer Service Line
5.5.1.4.9. Change of Provider forms
5.5.1.4.10. Instructions for a Reconsideration and/or a Peer-To-Peer review.
5.5.1.4.11. Direct links to the Department’s public website and the Department’s fiscal agent.
5.5.1.4.12. Messages requested by the Department.
5.5.1.5. The Contractor shall modify site content at the direction of the Department.
5.5.1.6. The Contractor shall deliver all site content to the Department for review and approval. The Contractor shall not publically post any content to the UM Website prior to the Department’s approval of that Content.
5.5.1.6.1. DELIVERABLE: UM Website Content
5.5.1.6.2. DUE: Four (4) weeks prior to the Operational Start Date.
5.5.2. UM Provider Web Portal
5.5.2.1. The Contractor shall establish and maintain a central UM Provider Web Portal through which Providers may submit PARs and view PAR review determinations.
5.5.2.1.1. The Contractor shall operate and maintain the UM Provider Web Portal according to Department-approved requirements.
5.5.2.1.2. The Contractor shall make the UM Provider Web Portal available to all Providers and the Department.
5.5.2.1.3. The Contractor shall be responsible for all costs in developing and maintaining the UM Provider Web Portal.
5.5.2.1.4. The Contractor shall ensure that the UM Provider Web Portal has the ability to:
5.5.2.1.4.1. Accept Provider PARs and HIPAA compliant attachments.
5.5.2.1.4.2. Perform automated reviews.
5.5.2.1.4.3. Allow role based user access via a secure log in.
5.5.2.1.4.4. Allow role based users to view and download data, analytics, or reports that shall include, but is not limited to, the following:

5.5.2.1.4.4.1. PAR status by Client or ordering Provider.
5.5.2.1.4.4.2. PAR results.
5.5.2.1.4.4.3. Reconsideration, Peer-To-Peer and Client Appeal results and options.
5.5.2.1.4.4.4. Client PAR history, which can be viewed and sorted by date, PAR type, approval, status and originating and/or submitting Provider.

5.5.2.1.4.5. Generate an ASC X12N/005010X217 (278U) Request transaction containing PAR data for transmission into the MMIS.
5.5.2.1.4.6. Receive PAR requests using an ASC X12N/005010X217 (278U) Acknowledgment transaction transmission containing final PAR disposition data from the MMIS.
5.5.2.1.4.7. Perform automated functions related to PAR submissions including, but not limited to, addition of points on medical necessity review tools, such as the PAT and PCAT, and unit or weight based PARs such as Synagis or Office Administered Drugs.
5.5.2.1.4.8. Alert Providers when they submit a PAR that is incomplete, such as when a PAR is submitted without necessary attachments or without answering necessary questions.
5.5.2.1.4.9. Alert Providers when the PAR submission does not contain all the required fields.
5.5.2.1.4.10. Allow Providers to request a PAR Reconsideration and/or a Peer-To-Peer review.

5.5.2.1.5. The Contractor shall assign a unique identifier when processing PARs that can also be viewed in the MMIS.
5.5.2.1.6. The Contractor shall ensure that a direct link is available for Providers to access the UM Provider Web Portal from the MMIS.

5.5.2.2. The Contractor shall deliver a test version of the UM Web Portal to the Department for review and approval.

5.5.2.2.1. DELIVERABLE: Test UM Provider Web Portal.
5.5.2.2.2. DUE: Six (6) weeks prior to the Operational Start Date

5.5.2.3. Once the Department has approved the test version of the UM Web Portal, the Contractor shall implement the UM Web Portal in a production environment and make it available to Providers and Department users.

5.5.2.3.1. DELIVERABLE: Production UM Web Portal
5.5.2.3.2. DUE: Four (4) weeks prior to the Operational Start Date.

5.5.2.4. The Contractor shall complete HIPAA Electronic Data Interchange (HIPAA EDI) trading partner testing and integration for 278U outbound transactions.
5.5.2.4.1. DELIVERABLE: Complete HIPAA EDI trading partner testing and integration.

5.5.2.4.2. DUE: Six (6) weeks prior to the Operational Start Date

5.5.2.5. The Contractor shall create a “smart” electronic PAR request form, customized for each service that requires a PAR. The Contractor shall design this form so that it reduces the chances of Technical/Administrative Denials due to incorrect or missing information.

5.5.2.5.1. DELIVERABLE: Smart PAR request forms.

5.5.2.5.2. DUE: Six (6) weeks prior to the Operational Start Date

5.5.2.6. User Access

5.5.2.6.1. The Contractor shall develop protocols for providing role-based user access to the UM Provider Web Portal.

5.5.2.6.1.1. The protocols shall include a requirement that users submit documentation supporting their level of access.

5.5.2.6.1.2. DELIVERABLE: UM Provider Web Portal User Access Protocol.

5.5.2.6.1.3. DUE: Six (6) weeks prior to the Operational Start Date.

5.5.3. MMIS Interface

5.5.3.1. Current MMIS

5.5.3.1.1. The Contractor shall:

5.5.3.1.1.1. Establish and maintain connectivity and access to the Department’s Current MMIS for the purpose of accessing claim, Client, Provider and other prior authorization information, as well as for transmitting prior authorization determinations and information into the System. Establishing and maintaining connectivity shall include, but not be limited to:

5.5.3.1.1.1.1. Test the transmission of Prior Authorizations with the Current MMIS prior to the Operational Start Date.

5.5.3.1.1.1.2. Test the transmission of PAR determinations and transmit PARS with the Current MMIS prior to the Operational Start Date.

5.5.3.1.1.1.3. After the Operational Start Date, for all changes made to the structure and/or transmission mechanisms of the Prior Authorization transactions of the Contract, the Contractor shall test the structure and transmission of Prior Authorizations with the Current MMIS and receive Department approval prior to implementation of these changes.

5.5.3.1.1.1.4. After the Operational Start Date, for all changes made to the structure and/or transmission mechanisms of the PAR determinations the Contractor shall test the structure and transmission of the PAR determinations with the Current MMIS and receive Department approval prior to implementation of these changes.
5.5.3.1.2. Send batches of electronic Prior Authorizations to the Current MMIS on a daily basis using a Department approved HIPAA compliant transaction format, including but not limited to the 278U transaction.

5.5.3.1.2.1. As determined by the Department, the Contractor shall manually perform any modifications to PAR content and/or records in the Current MMIS Production environment.

5.5.3.1.2.2. The Contractor shall resolve all errors that require manual intervention for all Prior Authorizations sent via a HIPAA compliant transaction format, including the 278U transaction format, that have errors that impede their acceptance into the Current MMIS.

5.5.3.1.3. Receive acknowledgement files from the Current MMIS back to the Contractor with Prior Authorization statuses as specified by the Current MMIS, Prior Authorization IDs and any error messages stopping the acceptance of a Prior Authorization into the Current MMIS.

5.5.3.2. Future MMIS

5.5.3.2.1. The Contractor shall:

5.5.3.2.1.1. Establish and maintain connectivity and access to the Department’s Future MMIS for the purpose of accessing claim, Client, Provider and other prior authorization information, as well as for transmitting Prior Authorization determinations and information into the System. Establishing and maintaining connectivity shall include, but not be limited to:

5.5.3.2.1.1.1. Test the transmission of Prior Authorizations with the Future MMIS during implementation of the Future MMIS.

5.5.3.2.1.1.2. Test the transmission of PAR determinations and transmit PARS with the Future MMIS during the implementation of the Future MMIS.

5.5.3.2.1.1.3. After the Operational Start Date, for all changes made to the structure and/or transmission mechanisms of the Prior Authorization transactions the Contractor shall test the structure and transmission of Prior Authorizations with the Future MMIS and receive Department approval prior to implementation of these changes.

5.5.3.2.1.1.4. After the Operational Start Date, for all changes made to the structure and/or transmission mechanisms of the PAR determinations the Contractor shall test the structure and transmission of the PAR determinations with the Future MMIS and receive Department approval prior to implementation of these changes.

5.5.3.2.1.2. Send batches of electronic Prior Authorizations to the Future MMIS on a daily basis using a Department-approved HIPAA compliant transaction format, including but not limited to the 278U transaction.

5.5.3.2.1.2.1. As determined by the Department, the Contractor shall manually perform any modifications to PAR content and/or records in the Future MMIS Production environment.
5.5.3.2.1.2.2. The Contractor shall resolve all errors that require manual intervention for all Prior Authorizations sent via a Department-approved HIPAA compliant transaction format, including the 278U transaction format, that have errors that impede their acceptance into the Future MMIS.

5.5.3.2.1.3. Receive acknowledgement files from the Future MMIS back to the UM vendor with Prior Authorization statuses as specified by the Future MMIS, Prior Authorization IDs and any error messages stopping the acceptance of a Prior Authorization into the Future MMIS.

5.5.3.2.1.4. The Contractor shall complete all testing and be able to transmit PARs prior to the Future MMIS going live.

5.5.4. Reporting Access

5.5.4.1. Current MMIS

5.5.4.1.1. The Contractor shall have access to COGNOS reporting.

5.5.4.1.2. The Contractor shall obtain all licenses as needed from the Current MMIS.

5.5.4.1.2.1. The Contractor shall be responsible for covering all costs associated with obtaining COGNOS licenses and shall not be paid separately for this cost.

5.5.4.2. Future MMIS

5.5.4.2.1. The Contractor shall have access to the reporting functions in the Future MMIS and the Department’s Business Intelligence and Data Management Services (BIDM).

5.5.4.2.2. The Contractor shall obtain all licenses as needed from the Future MMIS and BIDM.

5.5.4.2.2.1. The Contractor shall be responsible for covering all costs associated with obtaining the licenses for the reporting functions in the Future MMIS and BIDM and shall not be paid separately for this cost.

5.5.4.2.3. The Contractor shall establish its access to the reporting functions in the Future MMIS and the Department’s BIDM prior to the Future MMIS going live.

5.5.5. Provider Notification

5.5.5.1. The Contractor shall generate and send a 278U Transaction to the Department’s Fiscal Agent, on a schedule determined by the Department. The Department’s Fiscal Agent will send Review Notifications to Clients and Providers.

5.5.5.2. The Contractor shall make the Review Notification available on the UM Provider Web Portal.

5.5.5.3. For those reviews that are paper-based the Contractor shall enter the decision into MMIS.

5.5.5.4. The Contractor shall work with the Current MMIS and Future MMIS to install the live version of the MMIS on the Contractor’s computers.

5.5.6. PAR Revisions

5.5.6.1. The Contractor shall develop a process for completing all necessary PAR Revisions.
5.5.6.2. The Contractor shall manually enter all PAR Revisions into the MMIS at the request of the Department or in the following instances:

5.5.6.2.1. A Client Appeal, Retrospective Review, Peer-To-Peer and/or Reconsideration final determinations.

5.5.6.2.2. A Provider requests to add services to an existing active PAR.

5.5.6.2.3. The Department has requested a time extension on a PAR or PARs.

5.5.6.2.4. An existing, active PAR must be inactivated and a new PAR must be created for another Provider.

5.5.6.2.5. A Change of Provider Form is submitted to the Contractor by the new Provider.

5.5.6.2.6. A new billing Provider takes over established PARs under the previous Provider’s identification number.

5.5.6.2.7. PARs that have been electronically transmitted into, and accepted by, the MMIS and contain errors that must be fixed before claims can be paid against them.

5.5.6.2.8. Other MMIS related transmittal issues.

5.5.6.3. The Contractor shall coordinate directly with Providers to obtain all necessary data to complete PAR revisions.

5.5.7. UM Provider Web Portal User Training and Help Desk.

5.5.7.1. The Contractor shall provide training, technical assistance and help desk support services for all users that access the UM Provider Web Portal.

5.5.7.2. The Contractor shall:

5.5.7.2.1. Operate the UM Provider Web Portal Help Desk and be available for Providers during Business Hours.

5.5.7.2.2. Make written materials available on the Provider UM Web Portal to inform Providers about how to use the UM Provider Web Portal.

5.5.7.2.3. Provide ongoing operational support and maintenance of the UM Provider Web Portal.

5.5.7.2.4. Develop telephonic, self-directed and web interactive training modules to be delivered through the UM Website.

5.5.7.2.4.1. The Contractor shall deliver all training modules to the Department for review and approval.

5.5.7.2.4.1.1. DELIVERABLE: Training Modules

5.5.7.2.4.1.2. DUE: Six (6) weeks prior to the Operational Start Date.

5.5.7.2.4.2. The Contractor shall make all training modules available to users once the Department has approved the training modules.
5.5.7.2.5. Establish user logons and passwords, ensuring that the user’s security profiles are sufficient to protect personal health information in accordance with applicable federal and state laws. This includes maintaining the appropriate level of security to protect confidential information as specified in the Colorado Cyber Security Policies and HIPAA requirements.

5.5.7.2.6. Define user roles and permissions. The Contractor shall create a user roles and permissions guide that contains a description of all user roles and permissions.

5.5.7.2.6.1. DELIVERABLE: User roles and permissions guide.
5.5.7.2.6.2. DUE: Within ninety (90) days following the Effective Date.

5.5.7.2.7. Develop and submit an Operational Incident and Notification Report to the Department any time the UM Provider Web Portal is inaccessible to Provider and/or is not functioning properly.

5.5.7.2.7.1. This notification report shall include:
5.5.7.2.7.1.1. A description of the nature of the problem.
5.5.7.2.7.1.2. The expected impact on ongoing functions.
5.5.7.2.7.1.3. A corrective action plan.
5.5.7.2.7.1.4. The expected time of problem resolution.

5.5.7.2.7.2. The Contractor shall submit the Operational Incident and Notification Report within one (1) hour of when the Contractor determines or becomes aware that the system is not functioning properly or is inaccessible.

5.5.7.2.7.2.1. DELIVERABLE: Operational Incident and Notification Report.
5.5.7.2.7.2.2. DUE: Within one (1) hour of identification of the problem.

5.5.7.2.7.3. The Contractor shall notify the Department when the UM Web Portal functionality is restored after each incident.

5.5.7.2.8. Maintain a running list of all such occurrences per SFY in the Utilization Review Monthly Report.

OFFEROR'S RESPONSE 5. Provide a description of the functionalities and features of the UM Web Portal that Offeror will provide. Include information about:

a. How many users can access the UM Web Portal at any given time.

b. Provide a description of automated functions related to PAR submissions that the UM Web Portal will be able to perform.

c. Provide a description of the data, analytics and reports that a user will be able to view and download via the UM Web Portal.

d. Provide a description of the UM Web Portal’s real-time or near real-time capabilities for providing the review status of a PAR, results of PARs and any reasons for PAR denials. Include an estimated time for information availability.
e. Provide a description of the UM Web Portal’s Smart PAR Submission capabilities and processes. Include a description of the incorrect and missing information that the system will notify Providers about and a sample of the notification error messages Providers will receive.

5.6. CLIENT OVER-UTILIZATION PROGRAM (COUP)

5.6.1. The Contractor shall assist the Department in administering and expanding a Client Over-Utilization Program (COUP) for all Clients who are utilizing services inappropriately. For current COUP population data see Attachment M.

5.6.2. The Contractor shall develop and, upon Department approval, implement Expanded COUP Criteria and Processes, in addition to the criteria established in 10 CCR 2505-10 § 8.075, that, at a minimum:

5.6.2.1. Develops criteria and processes for identifying Clients who currently meet COUP criteria.

5.6.2.2. Establishes Exclusion Criteria for Clients who should be exempt from COUP.

5.6.2.3. Uses claims data on a quarterly basis to identify Clients meeting COUP criteria.

5.6.2.4. Identifies Clients appropriate for the twelve (12) month Lock-In Period.

5.6.2.4.1. The Contractor shall not place a Client into COUP during the Warning Period.

5.6.2.4.2. The Contractor shall not place a Client into COUP during the Client Appeal time period designated in CCR 2505-10 8.075.4.B.

5.6.2.4.3. If a Client appeal has been filed, the Contractor shall refrain from placing the Client into COUP until receiving notification of the appeal outcome.

5.6.2.5. Includes any additional criteria as directed by the Department.

5.6.3. The Contractor shall deliver a Draft Expanded COUP Criteria and Processes for Department review and approval.

5.6.3.1. DELIVERABLE: Draft Expanded COUP Criteria and Processes

5.6.3.2. DUE: Six (6) weeks prior to the Operational Start Date

5.6.4. The Contractor shall deliver a final Expanded COUP Criteria and Processes that incorporates any changes to the Draft COUP Criteria for Department review and approval.

5.6.4.1. DELIVERABLE: Expanded COUP Criteria and Processes

5.6.4.2. DUE: Four (4) weeks prior to the Operational Start Date

5.6.5. The Contractor shall deliver an Updated Expanded COUP Criteria and Processes that incorporates any changes to the Expanded COUP Criteria and Processes that are required by, or approved by, the Department by July 1st of each State Fiscal Year following the first year of the Contract.

5.6.5.1. DELIVERABLE: Updated Expanded COUP Criteria and Processes

5.6.5.2. DUE: July 1st of each State Fiscal Year beginning July 1, 2016
5.6.6. **COUP Client Appeals**

5.6.6.1. The Contractor shall assist the Department in all COUP related Client appeals as described in Section 5.4.4.7.

5.6.7. **Client Communications**

5.6.7.1. The Contractor shall maintain a COUP Direct Point of Contract that is staffed during the Department’s Business Hours, which will be available for:

5.6.7.1.1. Clients and Providers to call to ask questions regarding the Client’s status and general COUP inquiries.

5.6.7.1.2. Providers to call to ask questions and troubleshoot problems concerning COUP Clients.

5.6.8. The Contractor shall create and deliver COUP Client Communication Templates for use in all Client communications related to COUP.

5.6.8.1. The COUP Client Communications Templates shall include, at a minimum:

5.6.8.1.1. A Warning Letter to individuals meeting COUP criteria to notify them of potential placement into COUP.

5.6.8.1.2. A COUP Enrollment Letter to Clients who continue to meet COUP Criteria following the Warning Period to notify them of COUP enrollment.

5.6.8.1.3. All written communication templates shall include a telephone number to the Contractor’s COUP Direct Point of Contact.

5.6.8.2. The Contractor shall deliver all COUP Client Communication Templates to the Department for review and approval four (4) weeks prior to the Operational Start Date.

5.6.8.2.1. DELIVERABLE: COUP Communication Templates

5.6.8.2.2. DUE: Four (4) weeks prior to the Operational Start Date

5.6.9. The Contractor shall work collaboratively with the Department and the RCCOs to serve COUP Clients. At a minimum, the Contractor shall:

5.6.9.1. Communicate directly with all RCCO Project Managers and RCCO Providers who serve COUP Clients, this may include RCCO Care Coordinators and PCMPs who accept COUP Clients.

5.6.9.2. Communicate directly with all Non-ACC Providers who serve COUP Clients.

5.6.9.3. Educate Providers about COUP, how the program works, how Lock-In Providers should work with Clients and how Providers that are not the Lock-In Provider should handle Clients requesting services.

5.6.9.3.1. COUP Providers may include emergency departments, physicians and pharmacies.

5.6.9.4. Assist RCCOs in recruiting Providers, including Pharmacies and non-RCCO Primary Care Providers, to participate in COUP and serve as Lock-in Providers as described in CCR 2505-10 § 8.075.
5.6.10. The Contractor shall develop and deliver a COUP Communication, Recruitment and Education Plan that describes how the Contractor will complete the Work under Section 5.6.13.

5.6.10.1. DELIVERABLE: Communication, Recruitment and Educational Plan

5.6.10.2. DUE: Four (4) weeks prior to the Operations Start Date

5.6.11. COUP Client List

5.6.11.1. The Contractor shall compile an updated COUP Client List for distribution quarterly. The Contractor shall compile and distribute the COUP Client List in accordance with HIPAA standards.

5.6.11.2. The Contractor shall create and submit a COUP Client List Template to the Department for review and approval.

5.6.11.2.1. The COUP Client List shall contain details for each Client in the Warning Period or enrolled in COUP and shall include, at a minimum:

- 5.6.11.2.1.1. Client’s name.
- 5.6.11.2.1.2. Client’s Medicaid ID.
- 5.6.11.2.1.3. Client’s address and phone number.
- 5.6.11.2.1.4. Client’s assigned RCCO.
- 5.6.11.2.1.5. The COUP Criteria met.
- 5.6.11.2.1.6. Total amount of expenditures for each Client.
- 5.6.11.2.1.7. Whether Client is an ACC member or non-ACC member.

- 5.6.11.2.1.7.1. DELIVERABLE: COUP Client List Template
- 5.6.11.2.1.7.2. DUE: Four (4) weeks prior to the Operations Start Date

5.6.11.2.2. The Contractor shall deliver the COUP Client List to each RCCO, the SDAC and the Department on a quarterly basis by the tenth (10th) calendar day of the following calendar quarter.

- 5.6.11.2.2.1. DELIVERABLE: COUP Client List
- 5.6.11.2.2.2. DUE: By the tenth (10th) calendar day of each calendar quarter

5.6.12. The Contractor shall:

5.6.12.1. Monitor COUP Clients during the initial twelve (12) month lock-in period, and work with lock-in Providers to evaluate a Client’s need to remain in COUP.

5.6.12.2. Remove Clients from the COUP list when a medical determination has been made that placement into COUP is not clinically appropriate or after the twelve (12) month lock-in period has expired.

5.6.13. Criteria and Processes for Removing Clients
5.6.13.1. The Contractor shall create and deliver Criteria and Processes for Removing Clients from COUP that details the policies and processes Contractor will utilize in removing Clients from COUP.

5.6.13.1.1. DELIVERABLE: Criteria and Process for Removing Clients from COUP.

5.6.13.1.2. DUE: Four (4) weeks prior to the Operations Start Date.

5.6.13.2. The Contractor shall remove Clients from COUP in accordance with the approved Criteria and Processes for Removing Clients from COUP.

5.6.14. COUP Outcome Report

5.6.14.1. The Contractor shall create and deliver a COUP Outcome Report that includes, at a minimum:

5.6.14.1.1. The results of the COUP Clients’ initial 12-month lock-in period, including but not limited to:

5.6.14.1.1.1. Clients who are still on the COUP list after twelve (12) months.
5.6.14.1.1.2. Clients who were added to the COUP Client List that had previously been removed from the COUP Client List.
5.6.14.1.1.3. The costs and claims associated with each COUP Client.
5.6.14.1.1.4. An analysis of key statistics that shows, at a minimum:
5.6.14.1.1.4.1. Cost savings and Client utilization of services in COUP.
5.6.14.1.1.4.2. A breakdown of Clients by ACC members and non-ACC members.
5.6.14.1.1.4.3. A breakdown that includes an analysis of the program generally, analysis of individual RCCOs and analysis of individual Providers within each RCCO.

5.6.14.2. The Contractor shall deliver the COUP Outcome Report by July 31st of each Contract Year after the expiration of the initial Contract Year.

5.6.14.2.1. DELIVERABLE: COUP Outcome Report

5.6.14.2.2. DUE: Annually by July 31st each year after the expiration of the initial Contract Year

OFFEROR'S RESPONSE 6. Provide a draft of the Communication, Recruitment and Educational Plan for Providers with regard to COUP.

OFFEROR'S RESPONSE 7. Provide a description of how the Offeror will identify Clients for the COUP Program and communicate with COUP Clients.

OFFEROR'S RESPONSE 8. Provide a description of how the Offeror will assist the Department in expanding the COUP Program.

5.7. NURSE ADVICE LINE

5.7.1. The Contractor shall administer the Nurse Advice Line (NAL) for all Medicaid Clients.
5.7.1.1. The Contractor may select a Subcontractor to perform this service or choose to subcontract with the incumbent NAL vendor.

5.7.1.1.1. In the event that the Contractor chooses a Subcontractor, the chosen Subcontractor shall be able to provide all services required in the Statement of Work.

5.7.1.1.2. The NAL Call Center Staff shall meet the following standards:

5.7.1.1.2.1. URAC Health Call Center standards (www.URAC.org).

5.7.1.1.2.2. Have a complete understanding of common Medicaid Client medical, social, economic, family and other needs.

5.7.1.1.2.3. Have the ability to help Clients understand how to access appropriate services through their Medicaid and other State benefits.

5.7.2. The Nurse Advice Line Call Center shall:

5.7.2.1. Operate twenty-four (24) hours a day, seven (7) days a week.

5.7.2.2. Use the Department’s toll free number dedicated to the Nurse Advice Line, separate from other numbers the Contractor may have. This number shall remain the property of the Department.

5.7.2.3. Utilize nationally recognized guidelines through appropriate clinical algorithm software to triage and respond to Client calls.

5.7.2.4. Assist Clients in making appropriate decisions about accessing medical care.

5.7.2.4.1.1. The Contractor shall access the MMIS to match the information provided by the caller to information contained in the MMIS. The Contractor shall provide NAL services to all individuals calling the NAL regardless of whether the Contractor can confirm the individual’s eligibility for Medicaid.

5.7.2.5. Address potential gaps in care for the Client that may be unique to a particular region or eligibility category, or unique to the Client.

5.7.2.6. Perform quality assurance that includes a call recording system. The Contractor shall make these recordings available to Department staff upon the Department’s request.

5.7.2.7. Have the capability to receive calls from Clients who speak Spanish as their primary language and Clients who are hearing and speech impaired.

5.7.2.8. Develop a process to handle inquiries from Clients in languages other than English and Spanish.

5.7.2.8.1. DELIVERABLE: Non-English or Spanish speaking Client Inquiry Process

5.7.2.8.2. DUE: No later than the Operational Start Date

5.7.2.9. Install, maintain and utilize an automatic call distribution system and call reporting system. The Contractor shall provide data and information from this system to the Department upon the Department’s request.

5.7.2.9.1. The system shall record and report the following information, at a minimum, on an hourly, daily, weekly and monthly basis, for the call center as a whole and for individual operators:
5.7.2.9.1.1. Call volume.
5.7.2.9.1.2. Call abandonment rates.
5.7.2.9.1.3. Amount of time all available lines are in use.
5.7.2.9.1.4. Average speed to answer.
5.7.2.9.1.5. Average call wait times.
5.7.2.9.1.6. Client specific information:
  5.7.2.9.1.6.1. Client name.
  5.7.2.9.1.6.2. Current zip code.
  5.7.2.9.1.6.3. Phone number.
  5.7.2.9.1.6.4. Medicaid ID number.
  5.7.2.9.1.6.5. A breakdown of how Clients learned of the NAL services.
  5.7.2.9.1.6.6. Presenting medical problem.
  5.7.2.9.1.6.7. NAL intervention and call result.
  5.7.2.9.1.6.8. Client intention following the NAL intervention.
  5.7.2.9.1.6.9. Any referral or informational/educational information given to the Client.
5.7.2.10. Develop and implement a technical solution in collaboration with the SDAC and Department for feeding Client specific information into the SDAC, at a minimum, on a daily basis.
5.7.2.11. Develop a plan to interface with the RCCOs.
  5.7.2.11.1. DELIVERABLE: NAL RCCO Interface Plan
  5.7.2.11.2. DUE: By the Operational Start Date
5.7.2.12. Distribute informational and/or educational material to Clients regarding internal and external programs.
  5.7.2.12.1. Information/educational materials include, but are not limited to:
    5.7.2.12.1.1. Federally Qualified Health Centers.
    5.7.2.12.1.2. EPSDT outreach and case management sites.
    5.7.2.12.1.3. Women, Infants, and Children (WIC) program offices.
    5.7.2.12.1.4. Behavioral Health Organizations (BHO).
    5.7.2.12.1.5. Presumptive Eligibility sites.
    5.7.2.12.1.6. Individual RCCOs.
    5.7.2.12.1.7. Other programs requested by the Department.
  5.7.2.12.2. The Contractor shall document when the NAL distributes information and educational materials and which Clients receive the materials.
    5.7.2.12.2.1. DELIVERABLE: Informational/Educational Materials Distribution Report.
5.7.2.12.2.2. DUE: Monthly by the 15th of the month following the month for which the report covers

5.7.2.13. Develop a report to determine the cost avoidance or return on investment for the Nurse Advice Line, and assist the Department in assessing how the Nurse Advice Line affects claims for specific Clients.

5.7.2.13.1. DELIVERABLE: Cost Avoidance or Return on Investment Report.
5.7.2.13.2. DUE: Six (6) months after Operational Start Date then annually on July 1st of each year.

5.7.3. Nurse Advice Line Plan
5.7.3.1. The Contractor shall develop a Nurse Advice Line Plan for increasing the NAL call rate.

5.7.3.1.1. The plan shall include a comprehensive marketing strategy to optimize the effectiveness of a Nurse Advice Line.
5.7.3.1.1.1. The Contractor shall incur all costs for the marketing strategy.
5.7.3.1.1.2. The plan may include but is not limited to face-to-face meetings with stakeholders including PCMPs, emergency department staff, RCCOs, enrollment brokers and others as appropriate or as requested by the Department. The Contractor shall evaluate the results of the marketing plan on call volumes and other Program indicators.
5.7.3.1.2. The Contractor shall update the plan semi-annually to reflect changes in circumstances, opportunities, or priorities.

5.7.3.1.2.1.1. DELIVERABLE: Nurse Advice Line Plan
5.7.3.1.2.1.2. DUE: By the Operational Start Date and updated semi-annually

OFFEROR'S RESPONSE 9. Describe how the Offeror will ensure that all NAL staff have a complete understanding of medical, social, economic and other family needs in order to be able to help Clients.

OFFEROR'S RESPONSE 10. Provide a summary of the NAL Daily Notification Process that the Offeror will incorporate into the Draft Nurse Advice Line Notification Process. Include a description of how the notifications will be made available to Providers and the Department.

OFFEROR'S RESPONSE 11. Provide a draft marketing strategy for increasing the number of Clients utilizing the NAL. Include a detailed description of how the Offeror will conduct outreach to Clients to inform them of the NAL (for example mailings, emails and website postings).

5.8. INSPECTION, MONITORING AND SITE REVIEWS
5.8.1. The Contractor shall make staff available to assist in any audit or inspection under the Contract.
5.8.2. The Contractor shall provide adequate space on the premises to reasonably accommodate the Department, state or federal personnel conducting all audits, site reviews or inspections.

5.8.3. Site Reviews

5.8.3.1. 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.

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

5.8.3.2. 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.

5.8.3.3. 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.

5.8.3.4. 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.

5.8.3.5. The Contractor shall respond to any negative findings with a Site Review Corrective Action Plan within seven (7) calendar days of the final report, specifying the action to be taken and time frames.

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

5.8.3.5.2. Upon review of the proposed Site Review 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.

5.8.3.5.3. Once the Department has approved the corrective action plan, the contractor shall implement the plan and the Contractor shall continue to progress via the Site Review Corrective Action Plan until the Contractor is found to be in complete compliance by the Department.

5.8.3.5.3.1. DELIVERABLE: Site Review Corrective Action Plan

5.8.3.5.3.2. DUE: Within seven (7) calendar days of receiving the final report

5.8.3.6. 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.

5.9. CORRECTIVE ACTION PLANS
5.9.1. 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.

5.9.1.1. The written response shall be sent to the Department within seven (7) calendar days of the Department’s request. Upon request, the Department may allow additional time to investigate and report.

5.9.1.1.1. DELIVERABLE: Compliance Concerns Response.

5.9.1.1.2. DUE: Within seven (7) calendar days of the Department’s request.

5.9.2. 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 three (3) calendar days of the receipt of a written request.

5.9.3. Corrective action plans shall include, but not be limited to:

5.9.3.1. A detailed time frame specifying the actions to be taken,

5.9.3.2. Contractor’s employee(s) responsible for implementing the actions,

5.9.4. The implementation time frames and a date for completion.

5.9.4.1. 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 three (3) 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.

5.9.4.2. DELIVERABLE: Corrective Action Plan

5.9.4.3. DUE: Within three (3) Business Days of receipt of a written request from the Department.

5.9.5. 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.

5.9.5.1. 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.

5.9.5.1.1. DELIVERABLE: Revised Corrective Action Plan.

5.9.5.1.2. DUE: Within one (1) Business Day of the Department’s rejection.

5.9.6. Upon acceptance by the Department the Contractor shall implement the corrective action plan.

5.9.7. The Contractor shall cooperate with any Department follow-up reviews or audits at any time after the initiation of the corrective action plan.

5.9.8. The Department staff shall monitor progress on the corrective action plan until the Contractor is found to be in compliance.
5.9.8.1. The 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.

5.9.9. 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.

5.9.10. The Department reserves the right to reduce the time frame for a corrective action if delivery of Covered Services for Members is adversely affected.

5.9.11. 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.

5.9.12. 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.

5.10. AD HOC PROJECTS

5.10.1. The Contractor shall work on ad hoc projects as requested by the Department. A project is ad hoc to the extent that it is not duplicative of the Contractor’s responsibilities outlined in Section 5.0 Statement of Work.

5.10.2. Ad hoc projects may include, but are not limited to, the following:

5.10.2.1. Quality of care reviews.

5.10.2.2. Assistance with fraud reviews.

5.10.2.3. DRG diagnosis code updates.

5.10.2.4. Special review or assessment projects to determine utilization patterns or Provider practices, not described elsewhere in this Statement of Work.

5.10.2.5. Retrospective reviews in addition to those discussed in Section 5.4, Utilization Review.

5.10.2.6. Client records including inpatient stays.

5.10.3. The Contractor shall ensure that any ad hoc project will not compromise any deliverable due dates specified in the Statement of Work.

5.10.4. The Department may initiate an ad hoc project by submitting a written request to the Contractor for an estimate of the hours and services required to complete the ad hoc project.

5.10.5. The Contractor shall respond, in writing, to the Department’s request for estimates within three (3) Business Days of receipt of the request. The Contractor’s response shall include:

5.10.5.1. An estimate of the hours needed to complete the project.

5.10.5.2. The activities and milestones required to complete the project.
5.10.6. In the event that the Contractor’s estimate of hours needed to complete the ad hoc project exceeds forty (40) hours, the Contractor’s response shall also include all of the following:

5.10.6.1. A description of the personnel commitments for the ad hoc project including:

5.10.6.1.1. The names of all persons assigned to the ad hoc project.
5.10.6.1.2. The work responsibilities of each person assigned to the ad hoc project.
5.10.6.1.3. The estimated hours that each person will need to complete his/her work responsibilities.

5.10.6.2. A timeline delineating the estimated completion dates of activities critical to the ad hoc project.

5.10.6.3. A breakdown of the hours required per critical activity.

5.10.7. The Department will review the Contractor’s response and may elect not to have the Contractor perform any or all of the ad hoc projects or may request changes to the Contractor’s response. The Department will elect to have the Contractor perform ad hoc projects at the Department’s sole discretion.

5.10.8. The Contractor shall not begin an ad hoc project without the prior written approval of the Department.

5.10.9. All deliverables resulting from ad hoc projects shall comply with the requirements listed in sub-section 5.1.7.

5.10.10. The Contractor shall not perform any ad hoc project for which funds are not available in this Contract. If additional funding is required, this Contract may be amended to add additional funds.

5.10.11. Additional funding for ad hoc projects may be added through an option letter at the rates bid by Offeror.

5.11. PERFORMANCE STANDARDS

5.11.1. Baseline Performance Standards

5.11.1.1. The Contractor shall meet or exceed all Baseline Performance Standards at all times during the term of this Contract. The Performance Standards under this Contract are as follows:

5.11.1.1.1. Nurse Advice Line Call Center

5.11.1.1.1.1. The average length of time callers are in the call queue before the call is answered shall be sixty (60) seconds or less during each calendar month.

5.11.1.1.1.1. PERFORMANCE STANDARD: Average monthly call wait time is less than sixty (60) seconds.

5.11.1.1.2. After a call has been answered, no more than five percent (5%) of callers during each calendar month shall be placed on hold for longer than one (1) minute without contact from a help desk representative. Contact shall include notification to the caller that an issue or question is still being reviewed or is in the process of being resolved.
5.11.1.1.2.1. PERFORMANCE STANDARD: No more than five percent (5%) of callers on hold for longer than one (1) minute during a month.

5.11.1.1.3. No more than two percent (2%) of total calls received during each month shall be abandoned. A call shall be considered abandoned if the caller hangs up after that caller has waited in the call queue for sixty (60) seconds or longer.

5.11.1.1.3.1. PERFORMANCE STANDARD: Call abandonment rate less than two percent (2%).

5.11.1.2. Prior Authorization Review – Technical Denials

5.11.1.2.1. Prior authorization reviews that result in a technical denial shall not exceed five percent (5%) of all prior authorization reviews in any given month. A technical denial shall include all denials of Prior Authorization Requests due to missing, inadequate or incomplete information of PAR Requests.

5.11.1.2.1.1. PERFORMANCE STANDARD: Technical denials shall not be more than five percent (5%) of all PAR Reviews done in a month.


5.11.1.3.1. The Contractor shall complete standard manual prior authorization reviews, final determinations and decisions for Peer to Peer and Reconsideration Reviews each month within four (4) Business Days from the time all information for the request is received.

5.11.1.3.1.1. PERFORMANCE STANDARD: Complete all manual PARs within four (4) Business Days.

5.11.1.4. Expedited Reviews

5.11.1.4.1. The Contractor shall complete expedited prior authorization reviews, expedited final determination and decisions for Peer to Peer and Reconsideration Reviews each month within two (2) Business Days of receiving the information necessary to complete the prior authorization review.

5.11.1.4.1.1. PERFORMANCE STANDARD: Complete all manual expedited PARs within two (2) Business Days.

5.11.1.5. Emergency Department Utilization

5.11.1.5.1. No more than three percent (3%) of total emergency room department visits per SFY are by Clients who use the emergency department six (6) or more times per year, including COUP Clients.

5.11.1.5.1.1. PERFORMANCE STANDARD: No more than three percent (3%) of total emergency room department visits are by Clients who use the emergency department six (6) or more times per year.

5.11.1.6. UM Web Provider Portal Uptime and Downtime

5.11.1.6.1. Uptime and Downtime apply to the Web Portal application and any system hardware owned or controlled by the Contractor. Determinations of or calculations relating to Uptime and Downtime shall not include any time that the Web Portal is unavailable due to scheduled maintenance.
5.11.1.1.6.2. Each month, Uptime shall be at least ninety-eight percent (98%) of the time that is not scheduled for maintenance or other Department-approved unavailability during that month.

5.11.1.1.6.2.1. PERFORMANCE STANDARD: Uptime of at least ninety-eight percent (98%).

5.11.1.1.6.3. The UM Provider Web Portal shall have no more than five (5) incidents of Downtime during any month.

5.11.1.1.6.3.1. PERFORMANCE STANDARD: No more than five (5) incidents of Downtime per month.

5.11.1.7. Provider Customer Service Line

5.11.1.7.1. Average telephone responsiveness is less than or equal to thirty (30) seconds.

5.11.1.7.1.1. Telephone Responsiveness only refers to calls that are answered by a live customer service representative during normal business hours and is measured from the time of the first ring to the time the Provider reaches a customer service representative.

5.11.1.7.1.1.1. PERFORMANCE STANDARD: Average telephone responsiveness is less than or equal to thirty (30) seconds.

5.11.1.7.2. The average length of time callers are in the call queue before the call is answered shall be sixty (60) seconds or less.

5.11.1.7.2.1. PERFORMANCE STANDARD: Average monthly call wait time is less than sixty (60) seconds.

5.11.1.7.3. The Contractor shall not keep any call in the queue for more than three (3) minutes after receipt of the call before the call is answered.

5.11.1.7.3.1. PERFORMANCE STANDARD: No call in queue for longer than three (3) minutes.

5.11.1.7.4. After a call has been answered, the Contractor shall not place more than five percent (5%) of callers on hold for longer than one (1) minute without contact from a customer service representative. Contact shall include notification to the caller that an issue or question is still being reviewed or is in the process of being resolved.

5.11.1.7.4.1. PERFORMANCE STANDARD: No more than five percent (5%) of callers on hold for longer than one (1) minute during a month.

5.11.1.7.5. Less than or equal to two percent (2%) of total calls received during each month shall be abandoned. A call shall be considered abandoned if the caller hangs up after that caller has waited in the call queue for sixty (60) seconds or longer.

5.11.1.7.5.1. PERFORMANCE STANDARD: Call abandonment rate less than or equal to two percent (2%).

5.11.2. Incentive Performance Standards
5.11.2.1. The Department reserves the right, at its sole discretion, to establish incentives for each year of the Contact.

5.11.2.2. The Contractor shall create and submit an annual Incentive Plan. The Incentive Plan shall include:

5.11.2.2.1. Areas of Work that the Contractor believes would benefit from additional focus and work by the Contractor.

5.11.2.2.2. The incentive or incentives that the Contractor proposes for the coming year.

5.11.2.2.3. Performance standards the Department will measure the Contractor on, if the Department chooses to establish the recommended incentives.

5.11.2.2.4. How much of the Incentive PMPM will be attributed to each incentive if the Contractor successfully completes all requirements outlined in the Incentive Plan.

5.11.2.2.4.1. DELIVERABLE: Incentive Plan

5.11.2.2.4.2. DUE: The Incentive Plan for the first year of the Contract is due as directed by the Department. All other years’ plans are due by June 15th for the following year.

5.12. REPORTING REQUIREMENTS

5.12.1. The Contractor shall provide all reports listed in this section in the format directed by the Department and containing the information requested by the Department.

5.12.2. Administrative Reporting

5.12.2.1. The Contractor shall provide an Administrative Report to the Department, upon the Department’s request, covering the period directed by the Department.

5.12.2.1.1. The Administrative Report shall contain all information regarding the Contractor’s staffing, expenses and revenues relating to the Work, as directed by the Department for the period that the report covers. This information may include, but is not limited to, all of the following:

5.12.2.1.1.1. Number of Full Time Equivalent per position category, as determined by the Department, and total salary expenditure for that position category.

5.12.2.1.1.2. Operating expenses broken out by category, as determined by the Department.

5.12.2.1.1.3. Number of staff that were newly hired and separated and number of vacant positions, broken out by position category, as determined by the Department.

5.12.2.1.1.4. Administrative revenues, such as payments by debt and interest revenues, broken out by source, as directed by the Department.

5.12.2.1.1.5. Administrative expenditures, such as payments to Subcontractors and Providers, broken out by source as directed by the Department.

5.12.2.1.1.6. Remaining cash-on-hand at the end of the period.
5.12.2.1.2. The Contractor shall deliver the Administrative Report to the Department within ten (10) Business Days following the request by the Department for that report. The Department may create a fixed schedule for the Contractor’s submission of the Administrative Report by delivering the schedule to the Contractor in writing. The Department may change or terminate any fixed schedule it creates by notifying the Contractor in writing of the change or termination.

5.12.2.1.2.1. DELIVERABLE: Administrative Report

5.12.2.1.2.2. DUE: Within ten (10) Business Days following the Department’s request. If the Department has delivered a fixed schedule to the Contractor, then the Contractor shall deliver the report as described in the most recent version of that schedule.

5.12.3. Immediate Reporting

5.12.3.1. The Contractor shall report, to the Department, any findings that are life threatening, fraudulent or require immediate remedial action by the Department or the Department’s Providers in order to assure that no harm comes to Medicaid Clients.

5.12.3.2. The Contractor shall make an immediate verbal report to the Department of the above findings. The Contractor shall provide written documentation of the findings to the Department within three (3) Business Days of making a verbal report.


5.12.4.1. The Contractor shall provide a Utilization Review Monthly Report that shall include, but is not limited to:

5.12.4.1.1. The total number of PARs requested for each category of service requiring a PAR during the month. The Contractor shall be able to identify and quantify specified subcategories of services of each PAR category for each of the following at the request of the Department:

5.12.4.1.1.1. The number of Technical/Administrative Denials issued.

5.12.4.1.1.2. The number of Manual Reviews completed within four (4) Business Days from the time all information for the request was received.

5.12.4.1.1.3. The number of Manual Reviews not completed within four (4) Business Days from the time all information for the request was received and the number of additional days until completion of the manual PAR.

5.12.4.1.1.4. The number of Automated PARs.

5.12.4.1.1.5. The number of Expedited Manually Reviewed PARs.

5.12.4.1.1.6. The number of Expedited Manual Reviews completed within two (2) Business Days of receiving the information necessary to complete the PAR.

5.12.4.1.1.7. The number of Expedited Manual Reviews not completed within two (2) Business Days of receiving the information necessary to complete the PAR.

5.12.4.1.1.8. The number of medical denials and partial denials issued.

5.12.4.1.1.9. Services and PAR categories that were appealed or appeals were requested.

5.12.4.1.1.10. The number of PAR Revisions.
5.12.4.1.1.11. The number of PARs completed by Reconsideration review and results of the reviews.
5.12.4.1.1.12. The number of PARs completed by Peer to Peer review and results of the reviews.
5.12.4.1.1.13. The number and description of all PARs reviewed for out of state services.
5.12.4.1.1.14. The number and description of all EPSDT reviewed services.
5.12.4.1.2. The PAR Provider Customer Service Line report, including but not limited to:
5.12.4.1.2.1. Call volume.
5.12.4.1.2.2. The number and percentage of calls that were answered within fifteen (15) seconds.
5.12.4.1.2.3. The number and percentage of calls answered within three (3) minutes.
5.12.4.1.2.4. The number and percentage of calls answered after three (3) minutes.
5.12.4.1.2.5. The number and percentage of calls left on voicemail.
5.12.4.1.2.6. The number and percentage of busy signal/abandoned calls.
5.12.4.1.3. The number and type of Retrospective Review activities that were conducted during the month.
5.12.4.1.4. A description of all overturned cases, appeals and corrective actions during the month.
5.12.4.1.5. Trends in review outcomes during the month, including:
5.12.4.1.5.1. Services with few or no denials of PAR requests.
5.12.4.1.5.2. Services with a high percentage of denials.
5.12.4.1.5.3. Patterns in Prospective PARs or Retrospective Review findings.
5.12.4.1.5.4. Patterns identified by individual RCCOs and non RCCO Providers.
5.12.4.1.6. Recommendations for further reviews, policy adjustments or operational changes based on the trends.
5.12.4.3. DUE: Thirty (30) days after the end of each month.
5.12.5. Out of State Services Report
5.12.5.1. The Contractor shall provide a Quarterly Out of State Services Report that shall include, but is not limited to:
5.12.5.1.1. A breakdown of all Out of State PARs reviewed, approved and denied.
5.12.5.1.2. Provider trends or outliers identified by place of service.
5.12.5.1.3. Utilization data and trends identified by place of service.
5.12.5.1.3.1. DELIVERABLE: Quarterly Out of State Services Report
5.12.5.1.3.2. DUE: Thirty (30) days after the end of the each quarter
5.12.6. Radiology Report
5.12.6.1. The Contractor shall provide a Quarterly Radiology Report that shall include, but not be limited to:

5.12.6.1.1. A breakdown of all radiology PARs reviewed, approved and denied by procedure code.
5.12.6.1.2. Provider trends or outliers identified by individual RCCOs and by non RCCO Providers.
5.12.6.1.3. Utilization data and trends identified by individual RCCOs and by non RCCO Providers.
5.12.6.1.3.1. DELIVERABLE: Quarterly Radiology Report
5.12.6.1.3.2. DUE: Thirty (30) days after the end of each quarter.

5.12.7. Long Term Home Health Report
5.12.7.1. The Contractor shall provide a Quarterly Long Term Home Health Report that shall include, but not be limited to:

5.12.7.1.1. A breakdown of all Long Term Home Health Services requested, approved and denied for services including Private Duty Nursing, CNA, RN and Personal Care.
5.12.7.1.2. A breakdown of Peer-To-Peer, Reconsiderations, and Client Appeals.
5.12.7.1.3. A breakdown of clients receiving multiple Long Term Home Health services.
5.12.7.1.4. Provider trends and outliers identified by Home Health agencies.
5.12.7.1.4.1. DELIVERABLE: Quarterly Long Term Home Health Report
5.12.7.1.4.2. DUE: Thirty (30) days after the end of each quarter.

5.12.8. Emergency Department Utilization Report
5.12.8.1. The Contractor shall provide a Quarterly Emergency Department Utilization Report that shall include, but not be limited to:

5.12.8.1.1. Emergency Room Utilization by Clients who use the ER greater than six (6) times per quarter including claims paid and cost of claims.
5.12.8.1.2. Provider trends and outliers identified by individual RCCOs and by non RCCO Providers.
5.12.8.1.3. Utilization data and trends identified by individual RCCOs and by non RCCO Providers.
5.12.8.1.3.2. DUE: Thirty (30) days after the end of each quarter.

5.12.9. DME Report
5.12.9.1. The Contractor shall provide a Quarterly DME Report that shall include, but not be limited to:
5.12.9.1.1. DME utilization trends reported by PAR category including outliers, high cost items, and denials based on availability of less expensive alternatives, or requested using miscellaneous codes.

5.12.9.1.2. Provider trends and outliers identified by individual RCCOs and by non RCCO Providers.

5.12.9.1.3. Utilization data and trends identified by individual RCCOs and by non RCCO Providers.

5.12.9.1.3.1. DELIVERABLE: Quarterly DME Report

5.12.9.1.3.2. DUE: Thirty (30) days after the end of each quarter.


5.12.10.1. The Contractor shall submit a Nurse Advice Line Report on the Nurse Advice Line activity. The report shall include at a minimum:

5.12.10.1.1. The total number of calls received by the Nurse Advice Line.

5.12.10.1.2. The total number of calls abandoned by the Nurse Advice Line.

5.12.10.1.3. The total numbers of calls offered (transferred to a queue waiting for a live agent) for the Nurse Advice Line.

5.12.10.1.4. Nurse Advice Line average speed to answer and average call wait times.

5.12.10.1.5. A summary of Clients utilizing the Nurse Advice Line including RCCO distribution data and daily Nurse Advice Line notifications to RCCOs.

5.12.10.1.6. A summary of the Clients’ Call Disposition following the call.

5.12.10.1.7. A status update of activities the Contractor is performing to increase Client awareness and utilization of the Nurse Advice Line.

5.12.10.1.8. Data on referral information supplied to Clients by the NAL. This includes but is not limited to referral information regarding the Department’s sister agencies or other Department run programs.


5.12.10.1.9.1. Trends including but not limited to the summary of Client health issues, nurse advice, Client intention as well as communication with Clients and Providers.


5.12.10.3. DUE: Thirty (30) days after the end of each month.

5.12.11. Performance Standards Reports

5.12.11.1. The Contractor shall submit a Performance Standards report to summarize the Contractor’s progress against the performance standards during the previous quarter. This report shall include but is not limited to:

5.12.11.1.1. The average length of time callers were in the NAL call queue before the call was answered.
5.12.11.1.2. The number of NAL callers placed on hold for longer than one (1) minute without contact from a help desk representative.

5.12.11.1.3. The number of NAL calls received that were abandoned.

5.12.11.1.4. The call rate maintained by the NAL.

5.12.11.1.4.1. The Contractor shall develop a methodology to determine the call rate maintained by the NAL. The Contractor shall deliver this methodology to the Department for review and approval.

5.12.11.1.4.1.1. DELIVERABLE: NAL Call Rate Methodology

5.12.11.1.4.1.2. DUE: No later than the Operational Start Date

5.12.11.1.4.2. Once the Department has approved the NAL Call Rate Methodology, the Contractor shall implement that methodology for all NAL Call Rate calculations.

5.12.11.1.4.3. The Department may direct the Contractor to update its NAL Call Rate Methodology. The Contractor shall make all updates to its NAL Call Rate Methodology as directed by the Department.

5.12.11.1.5. The number of prior authorization reviews that result in a Technical Denial.

5.12.11.1.6. The turnaround time for Manual Review PARS for each week during the month. This turnaround time shall further be broken out as follows:

5.12.11.1.6.1. Turnaround time for manual reviews.

5.12.11.1.6.2. Turnaround time for peer to peer final determinations.

5.12.11.1.6.3. Turnaround time for reconsideration final determinations.

5.12.11.1.7. The turnaround time for Expedited PAR Reviews for each week during the month. This turnaround time shall further be broken out as follows:

5.12.11.1.7.1. Turnaround time for manual reviews.

5.12.11.1.7.2. Turnaround time for peer to peer final determinations.

5.12.11.1.7.3. Turnaround time for reconsideration final determinations.

5.12.11.1.8. The number of Clients who used the hospital emergency department six (6) or more times, including dates of service.

5.12.11.1.9. The total number of emergency department visits by Clients with six (6) or more visits.

5.12.11.1.10. The total amount of uptime for the UM Web Portal.

5.12.11.1.11. The total amount of downtime for the UM Web Portal.

5.12.11.1.12. The average telephone responsiveness time for the Provider Customer Service Line.

5.12.11.1.13. The average length of time callers were in the Provider Customer Service call queue before the call was answered.

5.12.11.1.14. The average length of time callers were in the Provider Customer Service call queue after receipt of the call before the call is answered.
5.12.11.1.15. The number of Provider Customer Service callers placed on hold for longer than one (1) minute without contact from a customer service representative.
5.12.11.1.16. The number of Provider Customer Service calls received that were abandoned.
5.12.11.1.17. The total number of Clients with active eligibility during the quarter.
5.12.11.1.18. The total number of Providers who called the Provider Customer Service Line during the quarter.
5.12.11.1.19.1. The Contractor shall include, for every missed performance standard:
5.12.11.1.19.1.2. The specific cause of the problem.
5.12.11.1.19.1.3. The solution.
5.12.11.1.19.1.4. How the Contractor will avoid missing the performance standard in the future.
5.12.11.1.19.2. The Contractor shall ensure that the Department has access to systems and reports the Contractor used to measure its performance.
5.12.11.2. DELIVERABLE: Performance Standards Reports.
5.12.11.3. DUE: Monthly, within fifteen (15) days following the end of the calendar quarter for which the report covers.
5.12.12. Serious Reportable Events Report
5.12.12.1. The Contractor shall submit a Serious Reportable Events Report that summarizes the review and its findings within one hundred twenty (120) calendar days of concluding its Serious Reportable Events review. For this report, the Contractor shall at a minimum:
5.12.12.1.1. Use inpatient hospital data only, excluding psychiatric hospitals.
5.12.12.1.2. Allow for ninety (90) days of claims “run out” (or payment). The Contractor shall exclude claims that were denied or had no payment associated with them.
5.12.12.1.3. Include these variables in the summary report:
5.12.12.1.3.1. TCN.
5.12.12.1.3.2. First Date of Service.
5.12.12.1.3.3. Last Date of Service.
5.12.12.1.3.4. Hospital Medicaid ID.
5.12.12.1.3.5. Hospital Name.
5.12.12.1.3.6. Client Medicaid ID.
5.12.12.1.3.7. Original DRG assigned.
5.12.12.1.3.8. An indicator that specifies if this is an APR DRG with complications, without complications, or neither.
5.12.12.1.3.10. Hospital Billed Amount.
5.12.12.1.3.11. Third Party payments & Copay amounts.
5.12.12.1.3.12. Diagnosis Codes and Procedure Codes that are the reason for the event.


5.12.12.3. DUE: Within one hundred twenty (120) calendar days of concluding its Serious Reportable Events review.


5.12.13.1. The Contractor shall submit a cost-savings report following the completion of each SFY.

5.12.13.2. The Cost-Savings Report shall demonstrate both graphically and in narrative form the savings resulting from the PAR program using, but not limited to, data provided by the Department. The Department will provide the data in weekly feeds for analysis.

5.12.13.2.1. DELIVERABLE: Cost-Savings Report

5.12.13.2.2. DUE: Within ninety (90) days of receipt after the end of the Fiscal Year.

5.12.13.3. The methodology used to produce the cost-savings report is negotiable, but must be agreed upon between the Department and the Contractor prior to the Contractor starting work on the report.

5.12.13.3.1. DELIVERABLE: Cost-savings Reporting Methodology

5.12.13.3.2. DUE: Thirty (30) days before beginning work on the report

5.13. START-UP AND CLOSEOUT PERIODS

5.13.1. The Contract shall have a Start-Up Period and a Closeout Period.

5.13.1.1. The Start-Up Period shall begin on the Effective Date. The Start-Up Period shall end on the Operational Start Date of the Contract.

5.13.1.1.1. The Operational Start Date shall not occur until the Contractor has completed all requirements of the Start-Up Period, including, but not limited to, the completion of the operational readiness review contained in the Start-Up Plan, unless the Department provides written approval otherwise.

5.13.1.1.2. 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.
5.13.1.2. 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 by the Department of non-renewal. The Closeout Period shall end on the day that the Department has accepted the final deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

5.13.1.2.1. This Closeout Period may extend past the termination of the Contract and the requirements of the Closeout Period shall survive termination of the Contract.

5.13.2. Start-Up Period

5.13.2.1. During the Start-Up Period, the Contractor shall complete all of the following:

5.13.2.1.1. 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.

5.13.2.1.1.1. DELIVERABLE: Policies and Procedure Manual

5.13.2.1.1.2. DUE: The later of the Effective Date or thirty (30) days prior to the Operational Start Date

5.13.2.1.2. 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.

5.13.2.1.3. Create and implement the Business Continuity Plan described in Section 5.1.10.

5.13.2.1.4. Create and implement the Communication Plan described in Section 5.1.9.2.1.

5.13.2.1.5. Create and implement the Start-Up Plan described in Section 5.13.4.1.

5.13.2.1.6. Complete all steps, deliverables and milestones contained in the Department-approved Start-Up Plan.

5.13.2.1.7. Implement the Current MMIS interface as described in Section 5.5.3.1.

5.13.2.1.8. Complete all deliverables with the due date prior to July 1, 2015.

5.13.2.2. The Contractor shall provide weekly updates, to the Department, throughout the Start-Up Period, that show the Contractor’s status toward meeting the timelines and milestones described in the Department-approved Start-Up Plan.

5.13.2.2.1. DELIVERABLE: Weekly Start-Up Report

5.13.2.2.2. DUE: Weekly, no later than 4 pm each Monday

5.13.2.3. The Contractor shall ensure that all requirements of the Start-Up Period are complete by the deadlines contained in the Department-approved Start-Up Plan and that the Contractor is ready to perform all Work by the Operational Start Date.

5.13.3. Closeout Period

5.13.3.1. During the Closeout Period, the Contractor shall complete all of the following:
5.13.3.1.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department, as described in Section 5.13.4.2 and complete all steps, deliverables and milestones contained in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

5.13.3.1.2. Provide to the Department, or any other contractor at the Department's direction, all reports, data, systems, deliverables and other information reasonably necessary for a transition as determined by the Department or included in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

5.13.3.1.3. Ensure that all responsibilities under the Contract have been transferred to the Department, or to another contractor at the Department's direction, without significant interruption.

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

5.13.3.1.5. Notify all Providers that the Contractor will no longer be the UM Contractor. The Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, the Contractor shall deliver these notifications to all Providers but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

5.13.3.1.5.1. DELIVERABLE: Provider Notifications

5.13.3.1.5.2. DUE: Thirty (30) days prior to termination of the Contract

5.13.3.1.6. Notify all Clients in the COUP Program that the Contractor will no longer be the UM Contractor. 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 COUP Clients but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

5.13.3.1.6.1. DELIVERABLE: COUP Client Notifications

5.13.3.1.6.2. DUE: Thirty (30) days prior to termination of the Contract

5.13.3.1.7. 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.

5.13.3.2. The Department will perform a closeout review to ensure that the Contractor has completed all requirements of the Closeout Period. In the event that the Contractor has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract.

5.13.4. Start-Up and Closeout Planning

5.13.4.1. Start-Up Plan
5.13.4.1.1. During the Start-Up Period, the Contractor shall create a Start-Up Plan that contains, at a minimum, all of the following:

5.13.4.1.1.1. A description of all steps, timelines and milestones necessary to fully transition the services described in the Contract from a prior UM contractor to the Contractor.

5.13.4.1.1.2. A description of all steps, timelines, milestones and deliverables necessary for the Contractor to be fully able to perform all Work by the Operational Start Date.

5.13.4.1.1.3. A listing of all personnel involved in the start-up and what aspect of the start-up they are responsible for.

5.13.4.1.1.4. An operational readiness review for the Department to determine if the Contractor is ready to begin performance of all Work.

5.13.4.1.1.5. The risks associated with the start-up and a plan to mitigate those risks.

5.13.4.1.2. The Contractor shall deliver the Start-Up Plan to the Department for review and approval.

5.13.4.1.2.1. DELIVERABLE: Start-Up Plan

5.13.4.1.2.2. DUE: Within five (5) Business Days after the Effective Date

5.13.4.2. Closeout Plan

5.13.4.2.1. The Contractor shall create a Closeout Plan that describes all requirements, steps, timelines, milestones and deliverables necessary to fully transition the services described in the Contract from the Contractor to the Department to another contractor selected by the Department to be the UM contractor after the termination of the Contract. The Closeout Plan shall also designate an individual to act as a closeout coordinator, who will ensure that all requirements, steps, timelines, milestones and deliverables contained in the Closeout Plan are completed and work with the Department and any other contractor to minimize the impact of the transition on Clients and the Department. The Contractor shall deliver the Closeout Plan to the Department for review and approval.

5.13.4.2.1.1. DELIVERABLE: Closeout Plan

5.13.4.2.1.2. DUE: Thirty (30) days following the Effective Date

5.13.4.2.2. 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.

5.13.4.2.2.1. DELIVERABLE: Closeout Plan Update

5.13.4.2.2.2. DUE: Annually, by June 30th of each year

SECTION 6.0 COMPENSATION AND INVOICING

6.1. COMPENSATION
6.1.1. The compensation under the Contract shall consist of a Per Member Per Month (PMPM) Payment for UM work and a NAL Payment.

6.1.1.1. The compensation under the Contract may also include a PMPM for incentives and a payment for Ad Hoc Work.

6.1.2. UM PMPM Payment

6.1.2.1. The Contractor shall receive a UM PMPM Payment each month that consists of the following:

6.1.2.1.1. A Tier 1 UM PMPM Payment for each month in which the weekly average Manual PAR Review turnaround time for every week during the month is ten (10) days or less.

6.1.2.1.2. A Tier 2 UM PMPM Payment, in addition to the Tier 1 UM PMPM, for each month in which the weekly average Manual PAR Review turnaround time for every week during the month is four (4) days or less.

6.1.2.2. The Department will calculate UM PMPM Payment each week by multiplying the number of Clients in the Medicaid Program, not including CHP or managed care Clients, based on the number of Clients shown on the report that the Department presents to the Joint Budget Committee (JBC) for that month or such other report as determined by the Department. In the event that the Department determines that it will use a report other than the JBC report, it will provide notice to the Contractor through the use of a transmittal.

6.1.2.3. The Department will pay the UM PMPM Payment through the MMIS on the payment schedule for that system.

6.1.3. NAL Payment

6.1.3.1. The Contractor shall receive a Base NAL Payment each month.

6.1.3.2. The Contractor shall receive a Tier 1 NAL Payment, in addition to the Base NAL payment and any other Tier payments for each month in which the Contractor maintains at least a four percent (4%) call rate.

6.1.3.3. The Contractor shall receive a Tier 2 NAL Payment, in addition to the Base NAL payment and any other Tier payments, for each month in which the Contractor maintains at least a five percent (5%) call rate.

6.1.3.4. The Contractor shall receive a Tier 3 NAL Payment, in addition to the Base NAL payment and any other Tier payments, for each month in which the Contractor maintains at least a six percent (6%) call rate.

6.1.3.5. The Contractor shall receive a Tier 4 NAL Payment, in addition to the Base NAL payment and any other Tier payments, for each month in which the Contractor maintains at least a seven percent (7%) call rate.

6.1.4. Ad Hoc Payment

6.1.4.1. The Contractor may receive an Ad Hoc Payment for any month in which the Contractor completed Ad Hoc Work as described in Section 5.10.
6.1.4.1.1. An Ad Hoc Payment for a month shall be determined by multiplying the Contractor’s Hourly Ad Hoc Rate by the number of hours the Contractor worked on Ad Hoc work during that month, rounded to the nearest tenth (10th) of an hour.

6.1.5. Incentive PMPM

6.1.5.1. The Contractor may receive an Incentive PMPM of up to two cents ($0.02) PMPM if an incentive program is implemented and the Contractor meets all incentive requirements contained in the Incentive Plan as described in Section 5.11.2.

6.1.5.2. In the event that the Department pays the Contractor an Incentive PMPM, it will calculate the Clients for the PMPM in the same way that Clients were calculated for the UM PMPM Payment and will make that payment through the MMIS.

6.2. INVOICING AND PAYMENT PROCEDURES

6.2.1. The Contractor shall invoice the Department on a monthly basis, by the fifteenth (15th) Business Day of the month following the month for which the invoice covers. The Contractor shall not invoice the Department for a month prior to the last day of that month.

6.2.2. The invoice shall contain all of the following for the month for which the invoice covers:

6.2.2.1. The Base NAL Payment and any Tier NAL Payment due.

6.2.2.2. The cost for all Ad Hoc work performed by the Contractor during the month.

6.2.2.3. The Incentive PMPM amount earned during the month.

6.2.3. Payment of Invoices

6.2.3.1. The Department shall remit payment to the Contractor, for all amounts shown on an invoice, after the Department’s acceptance of that invoice. Acceptance of an invoice shall not imply the acceptance or sufficiency of any work performed or deliverables submitted to the Department during the month for which the invoice covers or any other month. The Department shall not make any payment on an invoice prior to its acceptance of that invoice.

6.2.3.2. The Department will review the submitted invoice, and compare the information contained in the invoice to the Department’s information. The Department will only accept an invoice after it has reviewed the information contained on the invoice and determined that all amounts are correct.

6.2.3.3. In the event that the Department determines that all information on an invoice is correct, the Department shall notify the Contractor of its acceptance of the invoice, in writing.

6.2.3.4. In the event that the Department determines that any information on an invoice is incorrect, the Department will notify the Contractor of this determination and what is incorrect on the invoice. The Contractor shall correct any information the Department determined to be incorrect and resubmit that invoice to the Department for review.

6.2.3.4.1. The Department will review the invoice to ensure that all corrections have been made.
6.2.3.4.2. If all information on the resubmitted invoice is correct, the Department will accept the invoice.

6.2.3.4.3. If any information on the resubmitted invoice is still incorrect, then the Department will return the invoice to the Contractor for correction and resubmission.

6.2.3.5. In the event that the Contractor believes that the calculation or determination of any payment is incorrect, the Contractor shall notify the Department of the error within thirty (30) days of receipt of the payment or notification of the determination of the payment, as appropriate. The Department will review the information presented by the Contractor and may make changes based on this review. The determination or calculation that results from the Department’s review shall be final. No disputed payment shall be due until after the Department has concluded its review.

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

6.2.3.7. For any payments made through the MMIS the Department will make those payments in accordance with Section 6.1.

6.3. BUDGET

6.3.1. The Department has a maximum available appropriation for each year of the Contract. The current maximum appropriation is $5,488,174.45 and in no event will the Contractor receive any payment greater than the maximum available appropriation.

6.3.2. The Department has a maximum available amount for each year of this project. Any proposal that has a bid price that exceeds the Department’s maximum available amount for that component may be rejected without further consideration. The Department’s maximum available amount for each component is as follows:

6.3.2.1. UM PMPM Payment

6.3.2.1.1. The maximum available amount for the Tier 1 UM PMPM for each year of the project is twenty three cents ($0.23).

6.3.2.1.2. The maximum available amount for the Tier 2 UM PMPM for each year of the project is six cents ($0.06)

6.3.2.2. NAL Payment

6.3.2.2.1. The maximum available amount for the Base NAL payment for each year of the project is sixty six thousand seven hundred sixty dollars and six cents ($66,760.06) per month.

6.3.2.2.2. The maximum available amount for the Tier 1 NAL payment for each year of the project is thirteen thousand nine hundred nineteen dollars and seventy seven cents ($13,919.77).

6.3.2.2.3. The maximum available amount for the Tier 2 NAL payment for each year of the project is thirteen thousand nine hundred nineteen dollars and seventy seven cents ($13,919.77).
6.3.2.2.4. The maximum available amount for the Tier 3 NAL payment for each year of the project is thirteen thousand nine hundred nineteen dollars and seventy seven cents ($13,919.77).

6.3.2.2.5. The maximum available amount for the Tier 4 NAL payment for each year of the project is thirteen thousand nine hundred nineteen dollars and seventy seven cents ($13,919.77).

6.3.2.3. Ad Hoc Payment

6.3.2.3.1. The maximum available hourly rate for the Ad Hoc Payment is eighty five dollars ($85.00) per hour.

OFFEROR'S RESPONSE 12. Offeror shall complete Appendix D, Pricing Worksheet, and will bid a UM PMPM Tier 1 Payment rate, a UM PMPM Tier 2 Payment rate, a NAL Base payment, a NAL Tier 1 payment, a NAL Tier 2 payment, a NAL Tier 3 payment, a NAL Tier 4 payment and an Ad Hoc Payment hourly rate for years one (1) through five (5) of the Contract. PMPM rates may be different for each year of the Contract. Offeror’s bid shall not exceed the maximum amounts as described in Section 6.3.

SECTION 7.0 EVALUATION METHODOLOGY

7.1. EVALUATION PROCESS

7.1.1. The evaluation of proposals will result in a recommendation for award of the Contract. The award will be made to the Offeror whose proposal, conforming to the solicitation, will be most advantageous to the State of Colorado, price and other factors considered.

7.1.2. The Department will conduct a comprehensive, thorough, complete and impartial evaluation of each proposal received.

7.1.3. The Department will select a vendor in compliance with C.R.S. §24-103-203(7) which states, “The award shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the state, taking into consideration the price and evaluation factors set forth in the request for proposal”

7.2. EVALUATION COMMITTEE

7.2.1. An Evaluation Committee will be established utilizing measures to ensure the integrity of the evaluation process. These measures include the following:

7.2.1.1. Selecting committee members who do not have a conflict of interest regarding this solicitation.

7.2.1.2. Facilitating the independent review of proposals.

7.2.1.3. Requiring the evaluation of the proposals to be based strictly on the content of the proposals.

7.2.1.4. Ensuring the fair and impartial treatment of all Offerors.
7.2.2. The objective of the Evaluation Committee is to conduct reviews of the proposals that have been submitted, to hold frank and detailed discussions among themselves, and to recommend an Offeror for award.

7.2.3. The Evaluation Committee will evaluate proposals to determine if each Offeror met all mandatory qualification requirements. The mandatory qualification requirements are scored on a Met/Not Met basis and only those proposals found by the Evaluation Committee to meet all mandatory requirements can be considered for a Contract resulting from this solicitation.

7.2.4. Proposals will then be evaluated by the Evaluation Committee using the evaluation criteria in Section 7.4. The evaluators will consider whether all critical elements described in the solicitation have been addressed, the capabilities of the Offeror, the quality of the approach and/or solution proposed, the price and any other aspect determined relevant by the Department.

7.2.5. The Evaluation Committee will determine which proposal is the most advantageous to the State of Colorado by performing a value analysis.

7.2.6. The Evaluation Committee will perform a value analysis by comparing the technical differences among proposals and whether these differences justify paying the cost differential provided in each Offeror’s proposal.

7.2.7. The Evaluation Committee will have discretion in determining the manner and extent to which it will utilize technical and cost evaluation results. For example, the Evaluation Committee may award to an Offeror with higher costs if the Committee determines that the benefits of the technical differences for that Offeror’s proposal outweigh the proposal’s cost difference.

7.2.8. Based on the Evaluation Committee’s value analysis, the Committee will provide a numerical ranking for each Offeror’s proposal. The Evaluation Committee will explain its value analysis and the numerical ranking in a written document.

7.2.9. The Evaluation Committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers. The Evaluation Committee may adjust its scoring based on the results of such activities. However, proposals may be reviewed and determinations made without such activities. Offerors should be aware that the opportunity for further explanation might not exist; therefore, it is important that proposal submissions are complete.

7.3. COMPLIANCE

7.3.1. It is the Offeror’s responsibility to ensure that Offeror’s proposal is complete in accordance with the direction provided within all solicitation documents. Failure of an Offeror to provide any required information and/or failure to follow the response format set forth in Appendix A, Administrative Information, may result in the disqualification of that Offeror’s proposal.

7.4. PROPOSAL EVALUATION CRITERIA

7.4.1. The evaluation criteria to be used in evaluating the proposals are as follows:

**MANDATORY**
Be designated as a Quality Improvement Organization (QIO) or QIO-like entity as described in Section 1152 of the Social Security Act. (OFFEROR’S RESPONSE 1)

<table>
<thead>
<tr>
<th>EVALUATION CRITERIA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Offeror’s Organizational Specific Experience (OFFEROR’S RESPONSE 2)</td>
<td></td>
</tr>
<tr>
<td>Detailed explanation of how Offeror will provide sufficient personnel to perform Work (OFFEROR’S RESPONSE 3)</td>
<td></td>
</tr>
<tr>
<td>Collaboration, UM Training, and detecting areas requiring trainings, outreach and data sharing (OFFEROR’S RESPONSE 4)</td>
<td></td>
</tr>
<tr>
<td>Description of the functionalities and features of the UM Web Portal that Offeror will provide. (OFFEROR’S RESPONSE 5)</td>
<td></td>
</tr>
<tr>
<td>Provide a draft of the Communication, Recruitment and Educational Plan for Providers with regard to COUP. (OFFEROR’S RESPONSE 6)</td>
<td></td>
</tr>
<tr>
<td>Provide a description of how the Offeror will identify Clients for the COUP Program and communicate with COUP Clients. (OFFEROR’S RESPONSE 7)</td>
<td></td>
</tr>
<tr>
<td>Provide a description of how the Offeror will assist the Department in expanding the COUP Program. (OFFEROR’S RESPONSE 8)</td>
<td></td>
</tr>
<tr>
<td>Describe how the Offeror will ensure that all NAL staff have a complete understanding of medical, social, economic and other family needs in order to be able to help Clients. (OFFEROR’S RESPONSE 9)</td>
<td></td>
</tr>
<tr>
<td>Provide a summary of the Nurse Advice Line Daily Notification Process that the Offeror will incorporate into the Draft Nurse Advice Line Notification Process. Include a description of how the notifications will be made available to Providers and the Department. (OFFEROR’S RESPONSE 10)</td>
<td></td>
</tr>
<tr>
<td>Provide a draft marketing strategy for increasing the number of Clients utilizing the NAL. Include a detailed description of how the Offeror will conduct outreach to Clients to inform them of the NAL (for example mailings, emails and website postings). (OFFEROR’S RESPONSE 11)</td>
<td></td>
</tr>
<tr>
<td>Price (OFFEROR’S RESPONSE 12)</td>
<td></td>
</tr>
</tbody>
</table>