# AGREEMENT AMENDMENT NO. 2

Original Agreement Routing Number 13-52357

## 1. PARTIES

This Amendment to the above-referenced Original Agreement (hereinafter called the "Agreement") is entered into by and between the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 (hereinafter called "HCPF" or the "Department"), and the Department of Public Health and Environment (hereinafter called "DPHE"), who may collectively be called the "Parties" and individually a "Party", both of which are agencies of the STATE OF COLORADO, hereinafter called the "State".

## 2. EFFECTIVE DATE AND ENFORCEABILITY

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

## 3. FACTUAL RECITALS

The Parties entered into the Agreement to provide funding for the administration of the various health programs, health systems and health care services. The purpose of this Amendment is to modify the Statement of Work to include changes to the various programs and extend the Agreement through June 30, 2016.

## 4. CONSIDERATION

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

## 5. LIMITS OF EFFECT

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

## 6. MODIFICATIONS

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

**A.** Section 4, Term, Subsection A, Term-Work Commencement is hereby deleted in its entirety and replaced with the following:

A. Term-Work Commencement

The Parties respective performances under this Agreement shall commence on July 1, 2012. This Agreement shall expire on June 30, 2016, unless sooner terminated or further extended as specified elsewhere herein. Either Party may terminate this Agreement by giving the other Party 30 days prior written notice setting forth the date of termination. Upon termination the liabilities of the Parties for future performance hereunder shall cease, but the Parties shall perform their respective obligations up to the date of termination.

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

## 7. START DATE

This Amendment shall take effect on July 1, 2015.

## 8. ORDER OF PRECEDENCE

Execpt for the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Agreement, the provisions of this Amendment shall in all respects supersede, govern, and control.

## 9. AVAILABLE FUNDS

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

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**THE PARTIES HERETO HAVE EXECUTED THIS INTERAGENCY AGREEMENT**

Persons signing for Parties hereby swear and affirm that they are authorized to act on behalf of their respective Party and acknowledge that the other Party is relying on their representations to that effect.

**STATE OF COLORADO**
John W. Hickenlooper, Governor

Department of Public Health and Environment

By: _____
Larry Wolk, MD, MSPH
Executive Director and Chief Medical Officer

Date: 6/16/15

Department of Health Care Policy and Financing

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

Date: 6/22/15

**ALL AGREEMENTS REQUIRE APPROVAL BY THE STATE CONTROLLER**

**STATE CONTROLLER**
Robert Jaros, CPA, MBA, JD

By: _____
Department of Health Care Policy and Financing

Date: 6/28/15

## EXHIBIT A-2, STATEMENT OF WORK

### 1. DEFINITIONS

1.1. Adult Day Services - means health and social services furnished in an Adult Day Services Center to ensure the optimal functioning of Home and Community Based Services (HCBS) clients.

1.2. Alternative Care Facility (ACF) - means a residential facility licensed by DPHE as an assisted living residence where Homemaker, Personal Care, protective oversight, social, and recreational services are provided to clients served under the HCBS waivers.

1.3. Behavioral Therapies - means intensive developmental behavioral therapies specific to the needs of a client with autism who is enrolled in the HCBS-CWA waiver.

1.4. Brain Injury Supported Living Program (SLP) - means a specialized residential program designed for HCBS-BI clients who have maximized their rehabilitative potential and who require 24-hour supervision, structure, and supportive services in a community based facility.

1.5. Certification - means documented acknowledgment that the provider has met standards established by the applicable legal authority, enabling the provider to be reimbursed for providing covered services either as initial, continuing or provisional.

1.6. CMS - means the federal Centers for Medicare and Medicaid Services.

1.7. Community Transition Services (CTS) - means activities essential to move a client from a skilled nursing or intermediate care for individuals with intellectual and developmental disabilities facility and establish a community-based residence.

1.8. Day Treatment - means rehabilitative therapeutic services furnished to persons with brain injury in a Day Treatment center, encompassing physical, occupational, speech, and cognitive therapies.

1.9. Deficiency - means a finding that a provider is out of compliance with an applicable state or federal regulation.

1.10. Home and Community Based Services (HCBS) - means a state and federally approved community based service provided to individuals eligible for Medicaid long term services and supports promulgated under a 1915(c) HCBS Waiver. For purpose of this agreement where HCBS is used the term HCBS incorporates all services approved by the CMS and provider types certified by Medicaid under this agreement except for Alternative Care Facilities.

1.10.1. 1915(c) Waivers are optional programs available to states to allow provision of long term care services in a home and community based setting under the Medicaid program. Colorado offers a variety of HCBS waivers and services to support person centered community living.

1.11. Home Health Agency (HHA) - means a free standing or hospital based agency that provides intermittent Home Health Services in the client's place of residence. Home Health Services include skilled nursing, home health aide services, and occupational, physical, and speech therapies.

1.12. Homemaker Services - means general household activities provided in the home in accordance with 10 C.C.R. 2505-10, Section 8.490.

1.13. Hospice - means a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual, and sociological care to terminally ill clients and their families.

1.14. Hospital Backup Level of Care Program - means a program in a nursing facility for medically stable clients who were in the hospital while seeking approval for the program and who meet the specific criteria in one of the following categories: ventilator-dependent, complex wound care or medically complex.

1.15. In Home Support Services (IHSS) - means services approved under a 1915(c) HCBS wavier that include the utilization of a trained attendant for health maintenance activities, personal care and or homemaker services to assist with the activities of daily living.

1.16. Immediate Jeopardy (IJ) - means a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident or client.

1.17. Licensure - means documented evidence that the provider has been licensed by CDPHE pursuant to 6 C.C.R. 1011-1.

1.18. Medicaid Funded Program – means a medical assistance program funded in part by state and federal monies pursuant to the provision of state and federal law.

1.19. Monitoring - means a survey process that may involve direct contact with clients, family, and/or other responsible individuals, interviewing clients, and reviewing records to verify that clients are receiving services in accordance with state and federal laws.

1.20. Occurrence - means an event resulting in unexplained deaths, missing persons, diverted drugs, abuse, or any of the other outcomes specified in Section 25-1-124(2), C.R.S. (2005).

1.21. Personal Care - means assistance with eating, bathing, dressing, personal hygiene, mobility, and other activities of daily living when skilled care is not required.

1.22. Pre-Admission Screening and Resident Review (PASRR) - means a pre-screening or review of all individuals who apply to or reside in a Medicaid certified nursing facility regardless of the source of payment for nursing facility services or the individual's diagnosis.

1.23. Private Duty Nursing (PDN) - means face-to-face skilled nursing services provided by Home Health Agency staff that is more individualized and continuous than nursing services available under the Home Health benefit or routinely provided in a hospital or nursing facility.

1.24. Risk-Based Survey Schedule - means a schedule by which a Survey is conducted according to the provider's history of previous surveys and complaints that allows for more frequent surveys of providers with Deficiencies and less frequent surveys for providers without Deficiencies or with minimal deficient practices.

1.25. Survey - means a review conducted to verify that a provider is in compliance with applicable legal authority, including statutes and regulations.

1.26. Transitional Living - means a residential program that prepares HCBS-BI clients to live independently by providing training, therapy, and 24-hour supervision over a six to twelve-month period.

## 2. PUBLIC HEALTH PROGRAMS COVERED IN THIS INTERAGENCY AGREEMENT

2.1.1. Breast and Cervical Cancer Program (BCCP)

2.1.2. Children and Youth Programs:

2.1.2.1. Colorado Home Interventions Program (CHIP)

2.1.2.2. Early Periodic Screening Diagnosis and Treatment (EPSDT)

2.1.2.3. Children's Health Survey (CHS)

2.1.3. HIV

2.1.4. Immunization Programs:

2.1.4.1. Colorado Immunization Section (CIS )

2.1.4.2. Colorado Immunization Information System (CIIS)

2.1.4.3. Vaccines for Children (VFC)

2.1.5. Oral Health Program

2.1.6. Primary Care Office Program (PCO)

2.1.7. Pregnancy Risk Assessment Monitoring System (PRAMS)

2.1.8. Colorado Central Cancer Registry (CCCR)

2.1.9. Maternal and Child Health Programs:

2.1.9.1. Maternal and Child Health County Data Sets

2.1.9.2. Maternal Health Outcomes Data Initiative

2.1.10. Health Facilities and Emergency Medical services: Survey and Certification

## 3. GENERAL RESPONSIBILITIES

3.1. Collaboratively, HCPF as the state Medicaid administration agency, and DPHE as the state Public Health programs and Survey and Certification agency, agree to work collaboratively

on the Medicaid funded health programs, services, health information systems, health facilities Survey and Certification, and any and all other provider certifications, licensing, or agency operations required.

3.2. DPHE and HCPF agree to provide the necessary reports, data and information described within this agreement timely and in accordance with the frequency, scope and duration specified.

3.2.1. Agencies agree to communicate any delays, reason for delay and resolve the delay in reporting during the term of this agreement.

3.3. Program Integrity and Fraud Coordination

3.3.1. The agencies agree to work collaboratively in the prevention of fraud, waste and abuse. Each agency shall report to the other the suspicion of fraud, waste or abuse to the appropriate program or state authority.

3.3.1.1. DPHE shall report suspected provider and recipient abuse or fraud to the HCPF program integrity unit.

3.3.1.2. HCPF shall report suspected provider or recipient abuse, neglect or fraud to the DPHE HFEMS complaint unit.

3.3.2. The parties agree that prior to any potential DPHE action against a Medicaid provider for violation of DPHE rules promulgated by the state Board of Health requiring notice, registration or licensing of a provider for operating outside of its area of business, CDPHE shall provide advance notice of such potential action to the Department's Program Integrity Manager. At the Department's discretion and prior to DPHE directing a notice of action to the provider, the Department may seek an Attorney General informal opinion regarding whether the circumstances justify a determination that the circumstances constitute a credible allegation of fraud under the Department's rules. DPHE may proceed to take the action it deems to be required under federal and state law one week after notifying the Department of its potential action, or sooner if emergency circumstances so warrant.

3.4. HIPAA

3.4.1. DPHE is not a business associate (BA) of HCPF for purposes of the following: BCCP, Children and Youth Programs, VFC, CIIS, HIV, Immunization Programs, Oral Health, PCO, PRAMS, CCCR, and Maternal and Child Health Programs as described in this statement of work. HCPF is providing data under these programs pursuant to section 25-1-122, C.R.S. and section 6 CCR 1009-7.

3.4.2. DPHE is not a business associate (BA) for purpose of provider and health facilities survey and certification. DPHE is providing provider/facility survey data pursuant to federal CMS – State Operation Manual requirements and CMS approved 1915 (C): Qualified Provider requirements.

3.5. Emergency Preparedness

3.5.1. DPHE and HCPF agree to collaborate to ensure that Medicaid and Medicare clients receive services in the event of an emergency or disaster. DPHE and HCPF will work

together to guarantee that clients continue to receive necessary and appropriate care during and following emergencies.

3.5.1.1. DPHE as the survey agency contracted by CMS shall be the lead on emergency action, and is responsible for health and safety oversight in the facilities surveyed. To improve outcomes for clients and facilities in emergencies, DPHE will report to HCPF on a frequency agreed upon by both agencies at the time of the emergency. These reports will include client locations and general status. DPHE and HCPF will collaborate on an ongoing manner for planning purposes.

3.5.1.2. HCPF will notify DPHE of known Medicaid clients to help with tracking in the event of an emergency. HCPF will work with DPHE to provide a seamless transition for Medicaid clients.

3.6. Data Sharing

3.6.1. The Parties may share all data necessary for either party to perform its obligations under this contract or to undertake the programs performed by each respective party, regardless of whether that specific data sharing is described in this Agreement or not.

3.6.2. This data sharing may include, but is not limited to, the following specific data sharing:

3.6.2.1. CDPHE providing institution-specific and aggregate data to HCPF pertaining to CACFP claims and payment information for adult day care institutions, as well as providing institution application, budget, management plan, and compliance monitoring information to as needed.

## 4. PROGRAM ADMINISTRATION OF VARIOUS HEALTH PROGRAMS, HEALTH SYSTEMS AND HEALTH CARE SERVICES

4.1. CENTER FOR HEALTH AND ENVIRONMENTAL INFORMATION AND STATISTICS

4.1.1. The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based survey of new mothers designed to monitor maternal experiences and behaviors before, during and after pregnancy.

4.1.1.1. PRAMS: DPHE responsibilities:

4.1.1.1.1. DPHE shall ensure that, each month, approximately 250 Colorado residents who have given birth in the previous two to four (2-4) months in Colorado are randomly selected from registered birth certificates to participate in PRAMS surveys.

4.1.1.1.2. DPHE shall ensure the survey be given in English and Spanish.

4.1.1.1.3. DPHE shall ensure survey responses be kept confidential.

4.1.1.1.3.1. Survey answers and personal information shall be kept confidential and answers to the questionnaire are grouped together

4.1.1.1.4. DPHE shall ensure a minimum of eighty (80) survey items of topics that include:

4.1.1.1.4.1. Unintended pregnancy

4.1.1.1.4.2. Contraceptive use

4.1.1.1.4.3. Prenatal care

4.1.1.1.4.4. Breastfeeding

4.1.1.1.4.5. Tobacco use (Smoking)

4.1.1.1.4.6. Drinking

4.1.1.1.4.7. Domestic violence

4.1.1.1.4.8. Maternal and infant health

4.1.1.1.5. DPHE shall take steps to maintain a 70% response rate on all surveys.

4.1.1.1.6. DPHE shall provide HCPF with a comparison of weighted Colorado PRAMS survey responses.

4.1.1.1.7. Comparison of weighted Colorado PRAMS survey responses shall be reported in aggregate by:

4.1.1.1.7.1. Individual questions

4.1.1.1.7.2. All respondents

4.1.1.1.7.3. Medicaid covered respondents

4.1.1.1.7.4. Non-Medicaid covered respondents

4.1.1.1.8. Comparison PRAMS survey responses are due to HCPF within ninety (90) calendar days of the receipt of weighted data from the federal Centers for Disease Control (CDC).

4.1.1.2. PRAMS: HCPF RESPONSIBILITIES

4.1.1.2.1. HCPF shall provide DPHE with data necessary to maintain a 70% survey response rate by providing a monthly record level match of selected mothers in order to obtain updated contact information such as address and phone numbers.

4.1.1.2.1.1. Record level match due to DPHE from HCPF by the last business of each month.

4.1.2. Colorado Central Cancer Registry

4.1.2.1. In accordance with section 25-1.5-101(1)(q)(i), C.R.S., DPHE maintains a statewide cancer registry that provides for compilation and analysis of appropriate information regarding incidence, diagnosis, treatment through end results, and other data designed to provide more effective cancer control for the citizens of Colorado. The Central Cancer Registry includes Medicaid claims data to help the state identify cancer cases in Colorado for residents that have not been previously reported by another source, and obtain treatment information on cases that have been previously reported.

4.1.2.2. Central Cancer Registry Data

4.1.2.2.1. HCPF shall provide quarterly reports to DPHE by the 15th day of the last month of each designated state fiscal quarter, claims data for the Colorado Central Cancer Registry.

4.1.2.2.1.1. Data shall at minimum include client name, date of birth, social security number, gender, race/ethnicity, diagnosis, procedure code(s), date of service and all other data that DPHE may need to comply with statute.

4.1.3. Maternal And Child Health Program, Epidemiology

4.1.3.1. Data collected for Medicaid and CHP+ children that are included in the maternal and child health county data sets are utilized by Colorado counties for public health and health services planning. Counties use the data to determine if progress is being made in increasing the number of Medicaid children who receive dental services and the number of eligible children enrolled in Medicaid or CHP+.

4.1.3.2. Maternal and Child Health program data are reported annually for the maternal and child health block grant.

4.1.3.3. For each data element described below HCPF will provide data by the unique client count for Medicaid eligible children and by CHP+ eligible children at any time during the most recent state fiscal year.

4.1.3.3.1. By December 01 of each state fiscal year HCPF will provide to DPHE the number of children ages 0 through 18 enrolled in Medicaid and CHP+ by county.

4.1.3.3.1.1. Element:

4.1.3.3.1.1.1. Percentage of CHP+ enrollees who received a periodic screen.

4.1.3.3.1.1.2. Number of children enrolled in Medicaid and CHP+ by race and ethnicity as reported health status indicators.

4.1.3.3.1.1.3. Number of children ages 0-18 enrolled in Medicaid and CHIP+ who received dental services.

4.1.3.3.2. By March 01 of each state fiscal year HCPF will provide to DPHE the number of children ages 0 through 18 enrolled in Medicaid and CHP+ by county.

4.1.3.3.2.1. Element:

4.1.3.3.2.1.1. Number of CHP+ enrollees whose age is less than 1 year who reported at least one periodic screen during the most recent state fiscal year.

4.1.3.3.2.1.2. Number of CHP+ enrollees whose age is less than 1 year during the most recent state fiscal year.

4.1.3.3.2.1.3. Number of unique children ages 0 through 19 eligible and enrolled in Medicaid or CHP+ for at least one day by race (white, black, American Indian or native Alaskan, Asian, native Hawaiian or other Pacific Islander, more than one race reported, other and unknown) during the most recent state fiscal year.

4.1.3.3.2.1.4. Number of unique children 0 through 19 eligible and enrolled in Medicaid for at least one day by ethnicity (Hispanic, non-Hispanic) during the most recent state fiscal year.

4.1.3.3.2.1.5. Number and percent of unique children 0 through 19 in receipt of TANF by race (white, black, American Indian or native Alaskan, Asian, native Hawaiian or other Pacific Islander, more than one race reported, other and unknown) during the most recent state fiscal year.

4.1.3.4. Maternal Health Outcomes Data Initiative (MHODI). The Maternal Health Outcomes Data Initiative is a collaboration between HCPF and DPHE to maximize the effective use of data information sharing for (claims data and birth certificate data) from both state agencies to measure and track maternal health outcomes.

4.1.3.4.1. HCPF shall by the 15th business day of the last month of each designated state fiscal quarter, submit to DPHE multiple lists of public health insurance clients for whom a delivery claim has been received within a defined period of time. Client (mother) identifiers shall include Medicaid ID, full name, date of birth, social security number, and delivery facility billing provider name (and/or doing-business-as name, if applicable).

4.1.3.4.2. DPHE shall, upon receipt of this MHODI list submit to HCPF by September 01 of each state fiscal year a report of health outcome reports based on birth certificate data comparing in aggregate to each other and statewide, the maternal health outcomes of the clients on the various lists provided by HCPF.

4.2. DISEASE CONTROL AND ENVIRONMENTAL EPIDEMIOLOGY

4.2.1. Immunization

4.2.1.1. For all Medicaid funded immunization programs covered under this agreement, DPHE shall ensure that any associated providers are compliant with all state and federal laws, regulation or policies set forth by both DPHE and HCPF.

4.2.2. Vaccines For Children (VFC)

4.2.2.1. VFC program is a federally funded and state-operated vaccine supply program for eligible children through age 18.

4.2.2.2. Vaccines For Children: DPHE Responsibilities

4.2.2.2.1. DPHE will coordinate with HCPF on the development of informational materials affecting Medicaid populations.

4.2.2.2.2. DPHE shall maintain and annually update protocols, guidelines, procedures and forms for use in the VFC program.

4.2.2.2.3. DPHE shall notify HCPF immediately upon notification by the Centers for Disease Control and Prevention (CDC) of any known or suspected VFC vaccine shortages or lack of timely VFC shipments which may fiscally impact HCPF or place HCPF at risk of reimbursing for privately purchased vaccine.

4.2.2.3. Vaccines For Children: HCPF Responsibilities

4.2.2.3.1. HCPF shall provide DPHE with the program data necessary to comply with all federal and state reporting requirements necessary to administer the program.

4.2.2.3.1.1. Ad hoc data will be requested through HCPF's data request review board.

4.2.2.3.2. HCPF shall provide DPHE a quarterly list of Medicaid enrolled providers by the fifteenth (15) business day of the last month in each state designated fiscal quarter.

4.2.2.3.2.1. Provider data shall include provider name, clinic/facility name, location address, telephone and fax number.

4.2.2.3.3. By April 15th of each calendar year, HCPF shall provide DPHE with a table showing all Colorado Medicaid children having at least one day of eligibility for the previous calendar year.

4.2.2.3.3.1. In accordance with VFC federal guidelines, annual data is sent to CDC to estimate Colorado's VFC eligible population.

4.2.2.3.3.1.1. Excluding Native Americans, the Children's Medicaid data will include all children aged 0 to 18 with age determined as of the end of the month.

4.2.3. Colorado Immunization Information System (CIIS)

4.2.3.1. CIIS is the state's immunization registry managed at DPHE Colorado, it is a confidential, population-based computer system that collects and distributes consolidated immunization information for Coloradoans of all ages in accordance with the Colorado Immunization Registry Act, codified at § 25-4-2403 C.R.S.

4.2.3.1.1. DPHE shall work in collaboration with HCPF and/or HCPF's vendor to provide data to calculate immunization rates for annual reporting and on an ad hoc basis.

4.2.3.1.2. DPHE shall provide data in a manner consistent with HCPF's measure protocol such as NCQA HEDIS protocol for state immunization registries

4.2.3.1.2.1. HCPF or its fiscal agent shall provide CIIS a dataset of all eligible clients enrolled in Medicaid as of the date the data are extracted from the Medicaid Management Information System (MMIS) by Wednesday of each week, per CIIS's latest flat file specifications document.

4.2.3.1.2.2. HCPF shall provide CIIS a dataset of immunization-related claims for all Medicaid and CHIP+ at the date of service, by Wednesday of each week.

4.2.3.1.2.2.1. Dataset shall include claims paid during the prior week and shall be limited to claims with procedure codes identified by CIIS per CIIS's latest flat file specifications document.

4.2.3.1.2.3. HCPF and CIIS program staff shall meet quarterly to analyze data and rectify discrepancies.

4.2.3.1.2.4. HCPF shall educate Medicaid providers to inform Medicaid clients of their right to opt-out of providing information to CIIS.

4.2.4. Colorado immunization program-reimbursement for immunization services

4.2.4.1. This program was designed to evaluate, and implement a Medicaid reimbursement for immunization services received at Local Public Health Agencies (LPHAs) in Colorado providing immunization services to all residents who come into their clinics.

4.2.4.1.1. DPHE shall collaborate with HCPF to address the federal subsidy for the Medicaid administration fee reimbursement as set forth in the affordable care act. Together, HCPF and DPHE will pursue any necessary policy and statute changes to include LPHAs in this subsidized increase.

4.2.5. Viral Hepatitis Program

4.2.5.1. In accordance with §§25-1.5-105 and 25-1-122, C.R.S., DPHE maintains a system for detecting and monitoring communicable and chronic diseases. The statutes enable DPHE to review, inspect, and obtain information from patient records that are pertinent, relevant, or necessary to a public health investigation. Patient consent is not required. The viral hepatitis compiles and analyzes data related to hepatitis B and C for the purposes of describing incidence, level of care, care outcomes, and other data designed to provide for more effective disease control for the citizens of Colorado. The Viral Hepatitis Program includes Medicaid claims data to help the state identify hepatitis B and hepatitis C cases in Colorado for residents that have not been previously reported by another source, and obtain treatment information on cases that have been previously reported.

4.2.5.2. HCPF shall provide monthly reports to DPHE by the 15th business day of the following month claims data for all individuals with an indication of hepatitis B or C.

4.2.5.3. Data shall, at minimum, include client name, date of birth, complete address, gender, race/ethnicity, diagnosis, procedure code(s), date of service and all other data that DPHE may need to comply with statute.

4.3. HIV care and treatment program (HIVCT)

4.3.1. The HIVCT, as described in §25-4-1411 C.R.S., exists to assure access to medical care for low income Coloradans living with HIV or AIDS.

4.3.1.1. This includes case management for Medicaid-eligible clients to ensure timely enrollment in Medicaid, ongoing engagement in medical care (including adherence to prescribed medications) and transition to an alternative plan if Medicaid eligibility terminates.

4.3.1.2. DPHE uses Medicaid data in accordance with §25-4-1402 C.R.S. for the treatment, control and investigation of HIV infection under §25-4-1404 (b), C.R.S.

4.3.2. DPHE and HCPF will agree on a list of NDC and procedure codes that comprise diagnosis or treatment of HIV for purposes of this report.

4.3.3. Medicaid HIVCT report

4.3.3.1. HCPF shall provide a monthly data report to DPHE staff designee by the last business day of the month following the reporting month.

4.3.3.1.1. HCPF's monthly HIVCT data report consists of a Medicaid client data which will be pulled for clients having an open eligibility span in the month which the report covers. For example, the monthly report for July 2013 would include all clients that meet HIVCT criteria that had at least one day of eligibility between July 1, 2013 and July 31, 2013.

4.3.3.1.2. HCPF will provide the following client-level elements:

4.3.3.1.2.1. Client first name

4.3.3.1.2.2. Client last name

4.3.3.1.2.3. Medicaid ID

4.3.3.1.2.4. Eligibility begin date

4.3.3.1.2.5. Eligibility end date

4.3.3.1.2.6. Date of birth

4.3.3.1.2.7. Client addresses (address line 1&2, city, state, zip code)

4.3.3.1.2.8. Client gender

4.3.3.1.3. HCPF will provide the following claims and billing elements:

4.3.3.1.3.1. Client ID

4.3.3.1.3.2. Claim type code and description (signifies inpatient hospital, outpatient hospital, practitioner, etc.)

4.3.3.1.3.3. ICD code and description (for all but pharmacy claims)

4.3.3.1.3.4. Procedure code and description (for professional level claims)

4.3.3.1.3.5. DRG code and description (for inpatient hospital claims)

4.3.3.1.3.6. First date of service

4.3.3.1.3.7. Last date of service

4.3.3.1.3.8. Reimbursed units ( for professional level claims)

4.3.3.1.3.9. Drug therapeutic class code ( pharmacy claims only)

4.3.3.1.3.10. Drug name (pharmacy claims only)

4.3.3.1.3.11. Drug NDC code (pharmacy claims only)

4.3.3.1.3.12. Agencies will agree on a list of NDC codes that comprise pharmaceutical or medical treatment of HIV for purposes of this report.

4.3.4. AD HOC data will be requested through HCPF's data request review board.

4.3.5. Birth Defects Monitoring and Prevention

4.3.5.1. Colorado Responds to Children with Special Needs (CRCSN) is a group of public health reporting programs, surveillance data and intervention. These programs include Autism, Muscular Dystrophy, Fetal Alcohol Syndrome, and other

congenital anomalies defined by DPHE. HCPF provides data necessary to help DPHE assess prevalence of children in the CRCSN health reporting groups.

4.3.5.2. HCPF shall provide annually, CRCSN data to CDPHE in June of each year.

4.3.5.2.1. HCPF's CRCSN data report shall include the following client and client claim level elements:

4.3.5.2.1.1. Client's Medicaid ID

4.3.5.2.1.2. Client's full name

4.3.5.2.1.3. Client's birth date

4.3.5.2.1.4. Client's addresses (address line 1&2, city, state, zip code)

4.3.5.2.1.5. Client's phone number(s)

4.3.5.2.1.6. Client's gender

4.3.5.2.1.7. Client's diagnosis codes

4.3.5.2.1.8. Provider contact information

4.3.5.2.1.9. The quarterly claim data shall be limited to clients within the following age limits:

4.3.5.2.1.9.1. Fetal alcohol syndrome up to age (10)

4.3.5.2.1.9.2. Autism up to age (10)

4.3.5.2.1.9.3. Muscular dystrophy no age limit

4.3.5.2.1.9.4. All other diagnosis codes up to age three (3)

4.4. Prevention Services

4.4.1. Women's Wellness Connection (WWC); Breast and Cervical Cancer Program (BCCP)

4.4.1.1. The BCCP, implemented July 1, 2002, was established by the Breast and Cervical Treatment Act of 2000, allowing Presumptive Eligibility (PE) and full Medicaid benefits to women for treatment of breast and cervical cancer (or precancerous condition) who have been screened through Colorado's National Breast and Cervical Cancer Early Detection Program, the Women's Wellness Connection (WWC), or by a provider whose screening activities are recognized by WWC.

4.4.2. BCCP:DPHE Responsibilities

4.4.2.1. Maintain and annually update service definitions, protocols, guidelines, procedures and forms for use in the WWC program.

4.4.2.2. Provide public education and outreach on BCCP to WWC Qualified Entities.

4.4.2.3. Review applications of potential Qualified Entities.

4.4.2.4. Monitor and assess WWC QEs pursuant to federal requirements and federal timelines and are compliant with required licensure, certification, insurance and any

other permits as necessary to perform services as required by rules established by the Medical Services Board.

4.4.2.5. DPHE shall submit a letter of notification to HCPF for additional Qualified Entities that become qualified throughout the year.

4.4.2.6. DPHE shall provide notification to the HCPF designated state authority of New Qualified Entities within fifteen (15) business days from the date the entity becomes qualified.

4.4.2.7. No later than September 01 of each fiscal year DPHE shall provide to the HCPF designated state authority(s) a report containing a listing of all current and appended Qualified Entities.

4.4.2.8. Ensure WWC Qualified Entities:

4.4.2.8.1. Provide cancer screening services including clinical breast examinations, pelvic examinations, Human Papillomavirus (HPV) and Papanicolaou tests, as well as other breast and cervical cancer screening services, such as mammograms.

4.4.2.8.2. Provide access to diagnostic services including surgical consultations and biopsies to women with abnormal screening results.

4.4.2.8.3. Perform Presumptive Eligibility (PE) determinations for clients with a confirmed diagnosis of breast or cervical cancer (or precancerous conditions).

4.4.2.8.4. Obtain a PE identification number.

4.4.2.8.5. Inform PE clients of the benefits available to them under Medicaid

4.4.2.8.6. Assist the client in completing the application for Health Coverage and Help Paying Costs. (Medicaid/CHP+ application). Submit the original application to the client's local county social/human services department within five (5) business days.

4.4.3. Provide verification to HCPF's BCCP coordinator that a woman has been screened or diagnosed under the WWC program and has a BCCP-eligible diagnosis.

4.4.3.1. Verification shall include, at a minimum, all of the following:

4.4.3.1.1. Client-signed "WWC consent" form.

4.4.3.1.2. Client-signed "Verification of Lawful Presence" affidavit.

4.4.3.1.3. Copy of pathology report which includes date of diagnosis and medical interpretation confirming diagnosis.

4.4.3.1.4. Copy of completed PE Form.

4.4.3.1.5. Copy of the signature page of the Application for Health Coverage and Help Paying Costs

4.4.4. DPHE shall provide an annual BCCP report to HCPF by October 31st of each year.

4.4.4.1. The report shall describe progress in meeting screening goals for the early detection of cancer in WWC qualified entities.

4.4.5. Within fifteen (15) business days of request by HCPF, DPHE shall provide monitoring and assessment information on WWC qualified entities.

4.4.6. DPHE shall reconcile monthly client data reports against their list of referred applicants.

4.4.6.1. DPHE shall verify through e-mail with authorized HCPF program designee that clients reported as eligible were approved by DPHE for the BCCP to ensure a 100% match.

4.4.6.1.1. Discrepancies shall be resolved with HCPF in three (3) business days.

4.4.7. BCCP:HCPF RESPONSIBILITIES:

4.4.7.1. HCPF shall provide DPHE with the data necessary to comply with all federal and state reporting requirements necessary to administer the program.

4.4.7.1.1. Data will be provided in an agreed upon format and submitted to DPHE electronically

4.4.7.1.2. HCPF program staff and DPHE program staff shall collaborate to analyze data and rectify discrepancies.

4.4.7.1.3. HCPF will provide data to DPHE in a monthly report containing the following client level elements:

4.4.7.1.3.1. Client first name

4.4.7.1.3.2. Client last name

4.4.7.1.3.3. Medicaid ID

4.4.7.1.3.4. Eligibility begin date

4.4.7.1.3.5. Eligibility end date

4.4.7.1.3.6. Date of birth

4.4.7.1.3.7. Client data will be pulled for clients with an open eligibility span (at least one day) in the month for which the report covers.

4.4.7.1.4. HCPF will provide data to DPHE in a monthly report containing the following claims-level elements:

4.4.7.1.4.1. Client ID

4.4.7.1.4.2. Claim type code with description (inpatient hospital, outpatient hospital, practitioner and/or provider.)

4.4.7.1.4.3. ICD diagnosis code and description (except pharmacy claims)

4.4.7.1.4.3.1. Agencies will agree on a list of diagnosis codes that comprise breast or cervical cancer for purposes of this report.

4.4.7.1.4.4. Procedure code and description (for professional level claims)

4.4.7.1.4.5. Diagnosis-related group (DRG) code and description (for inpatient hospital claims)

4.4.7.1.4.5.1. First date of service

4.4.7.1.4.5.2. Last date of service

4.4.7.1.4.5.3. Payment date

4.4.7.1.4.5.4. Payment amount (for institutional level claims)

4.4.7.1.4.5.5. Reimbursed units (for professional level claims)

4.4.7.1.4.5.6. Drug therapeutic class code (pharmacy claims only)

4.4.7.1.4.5.7. Drug therapeutic class description (pharmacy claims only)

4.4.7.1.4.5.8. Drug name (pharmacy claims only)

4.4.7.1.4.5.9. Drug National Drug Code (NDC) code (pharmacy claims only

4.4.7.1.4.6. Agencies will agree on a list of NDC codes that comprise pharmaceutical treatment of breast or cervical cancer.

4.4.7.1.4.7. Claims level reporting will be pulled based on payment of a claim in the reporting month.

4.4.8. Children, Youth and Families; (CYF); Newborn Hearing Screening Program (NBHP)

4.4.8.1. CYF staff in partnership with the Colorado School for the Deaf and Blind (CSDB), assists HCPF in obtaining qualified early interventionists, audiologists, speech therapists and deaf educators who provide services for children enrolled in Colorado Medicaid ages zero to three years with identified hearing loss for the Colorado Home Intervention Program (CHIP) certification.

4.4.8.2. Provider Certification:

4.4.8.2.1. DPHE shall ensure Colorado Home Intervention Program (CHIP) providers submit complete application documents compiled and affirmed by CSDB, in order to meet criteria mutually agreed upon by DPHE and HCPF.

4.4.8.2.2. DPHE shall submit to HCPF by July 31st of each year, a listing of providers determined to have met all DPHE certification requirements Certification.

4.4.8.2.3. DPHE shall submit a new Provider notification to HCPF Within ten (10) business days from certification.

4.5. DPHE CSBD Medicaid funded program responsibilities:

4.5.1. Meet at least quarterly with HCPF's Early And Periodic Screening, Diagnosis And Treatment (EPSDT) program administrator to discuss programs progress made on the following objectives:

4.5.1.1. Supporting existing EPSDT outreach and case management efforts for enrollees and families.

4.5.1.2. Supporting existing EPSDT federal requirements of 80% of the eligible children receive well child visits and oral health care visits starting by age one.

4.5.1.2.1. DPHE and EPSDT Medicaid navigators share mutually beneficial information.

4.5.1.3. Determine referrals for care coordination and work collaboratively to ensure minimal duplication of care coordination, services delivered through a medical home and clinic services.

4.5.1.4. Ensure that at least one DPHE staff sits on the EPSDT Children's Services Steering Committee.

4.5.2. Program Data sharing:

4.5.2.1. DPHE shall supply HCPF with child health survey data after each annual survey.

4.5.2.2. HCPF shall provide DPHE with developmental screening data collected from report 3715 (96110/96111) to include: total number of screenings, detail of screenings by provider and month, and screenings completed during a well child check on a quarterly basis.

4.5.2.3. HCPF shall provide DPHE with the program data necessary to comply with all federal and state reporting requirements necessary to administer the program including:

4.5.2.3.1. Aggregate number of children age 20 and under, who were enrolled in Medicaid and CHP+ each SFY, by county.

4.5.2.3.2. Aggregate number of children age 20 and under, who were enrolled in Medicaid and who have a disability, by county.

4.5.2.3.3. Aggregate number of children age 20 and under on SSI, by county.

4.5.2.3.4. Number of children age 20 and under who were enrolled in Medicaid by eligibility type.

4.5.2.3.5. CMS EPSDT 416 data shall be provided by the EPSDT Program Administrator by May 1 of each year.

4.5.2.3.6. HCPF shall submit all SFY required data by January 1st of each year.

4.6. HEALTH EQUITY: Oral Health Program

4.6.1. The oral health program is a state operated program for children age 20 and under. Through this program, dental providers are permitted to provide individualized dental care focused on hygiene and prevention. This program identifies geographic areas that have unmet oral health needs and would be appropriate for dental expansion. The oral health program increases the amount of dollars spent on oral health care and increases the number of Coloradoans who have access to dental services.

4.6.1.1. DPHE Shall:

4.6.1.1.1. Maintain and annually update service definitions, protocols, guidelines, procedures and forms for use in the program.

4.6.1.1.2. Ensure that clients age 20 and under and families with children in need of care coordination are referred to county EPSDT outreach and case management coordinators via written or telephone referral.

4.6.1.1.3. Coordinate with HCPF on development of any oral health informational materials affecting Medicaid populations.

4.6.1.1.4. Report suspected provider fraud and abuse to HCPF's program integrity section.

4.6.1.2. HCPF shall provide DPHE with the program data necessary to comply with all federal and state reporting requirements necessary to administer the program. Program data shall not include data protected under the health insurance portability and accountability act (HIPAA). Ad hoc data will be requested through HCPF's data request review board process.

4.6.1.3. HCPF shall provide to DPHE the Colorado annual EPSDT participation report (CMS 416) by April 30th each state fiscal year, for the previous state fiscal year).

4.6.1.4. HCPF shall provide to DPHE by December 31st each year, an annual report that includes a listing of referrals for restorative care for children by hygienists for the health resources and services administration (HRSA).

4.6.1.4.1. This report will provide data by state fiscal year and will include the number of children ages 20 years or younger as of June 30 of each year, who have been seen by hygienists, and number of these same children who have been seen by a dentist who provided restorative care.

4.6.1.4.2. HRSA annual report shall include the following:

4.6.1.4.2.1. Number of children enrolled in Title XIX Medicaid for at least 29 days.

4.6.1.4.2.2. Number of dentists actively enrolled as Medicaid providers.

4.6.1.4.2.3. Number of active, Medicaid-enrolled dentists with at least one paid claim.

4.6.1.4.2.4. Number of active, Medicaid-enrolled dentists with paid claims greater than $10,000.00.

4.6.1.4.2.5. Number of dentists actively enrolled as billing providers with at least one paid claim.

4.6.1.4.2.6. Number of dentists actively enrolled as rendering providers with at least one paid claim.

4.6.1.4.2.7. A list of the name and practice address of all dentists who have billed Medicaid at least once in the most recent twelve month period where data is available.

4.6.1.4.2.8. The sum cost of all oral health claims paid by Medicaid by census tract for the most recent twelve month period where data is available.

4.6.1.4.2.9. Number of active, Medicaid-enrolled dentists who saw 50 or more beneficiaries age 20 and under as of September 30.

4.6.1.4.2.10. Number of active, Medicaid-enrolled dentists who saw 100 or more beneficiaries age 20 and under as of September 30.

4.6.1.4.2.11. Number of counties in Colorado without an actively enrolled dental provider.

4.6.1.4.2.12. List of counties in Colorado without an actively enrolled dental provider.

4.6.1.4.2.13. Percentage of counties in Colorado with an enrolled dentist (appearing as the billing provider) on paid claims totaling less than or equal to $10,000.00.

4.6.1.4.2.14. Number of counties without an enrolled billing dentist who saw 50 or more beneficiaries age 20 and under.

4.6.1.4.2.15. Number of children by age and county receiving fluoride varnish, if applicable.

4.6.1.4.2.16. Number of non-dental providers by county billing for fluoride varnish, if applicable.

4.6.1.4.2.17. Number of dental providers by county billing for fluoride varnish, if applicable.

4.6.1.4.2.18. Number of all clinics billing for fluoride varnish, if applicable.

4.6.1.4.2.19. For the purposes of the annual HRSA oral health report the term dentist is defined as any provider with a provider type of "dentist" (including hygienists) and dental provider is defined as any provider with a provider type of either "dentist" or "dental clinic".

4.6.1.4.3. Data for each item on this report will be broken out by the following categories where applicable:

4.6.1.4.3.1. Dental provider

4.6.1.4.3.2. Dentists (includes hygienists)

4.6.1.4.3.3. Dentists (excluding hygienists)

4.6.1.4.3.4. Hygienists

4.6.1.4.3.5. FQHC/RHC

4.6.1.4.4. The annual report on oral health to HRSA shall cover the most recently completed federal fiscal year, from October 1st until September 30th.

4.6.1.5. Oral health program performance report

4.6.1.5.1. There is a goal of 30% of the children covered by EPSDT seen by a hygienist will subsequently be seen by a dentist. Baseline data for the prior state fiscal year will be used. Growth in children seen by a dentist will be measured by December 31st of each year.

4.6.1.5.2. The following data will be provided to monitor program performance:

4.6.1.5.2.1. Ratio of children receiving well child visits that also receive cavity-free at three services (denominator: kids that receive well child visits; numerator: kids that receive CF3 services) in each quarter

4.6.1.5.2.2. Number of children receiving CF3 services by billing and rendering provider in each quarter

4.6.1.5.2.3. Change in the number of clients served over time by billing provider

4.6.1.5.2.4. Ratio of clients receiving CF3 services that have a dental follow-up within six months by age group and quarter (denominator: kids that receive CF3 services; numerator: kids that have a restoration [line 12b from the 416] or a specified treatment [d0120, d0145, d0150, d0999, d1120, d1206] within six months of their CF3 service

4.6.1.5.2.4.1. The same ratio sorted by the CF3 provider and age group

4.6.1.5.2.5. Quarterly benefit management report for Medicaid dental services-utilization and expenditure patterns for the dental benefit.

4.7. HEALTH EQUITY: Primary Care Office (PCO)

4.7.1. DPHE helps ensure that Colorado counties are assessed for "low-income" and "Medicaid eligible" health professional shortage area applications annually.

4.7.2. The PCO function under DPHE makes application to HRSA for health professional shortage area designations.

4.7.3. Medicaid provider and enrollment data is essential to qualifying an application for submission.

4.7.3.1. HCPF provides DPHE with data necessary to perform assessment of "low income" and "Medicaid eligible" health professional shortage areas by February 28 each calendar year. The data shall include:

4.7.3.1.1. HCPF: PCO Reports

4.7.3.1.1.1. A list of the name, practice address, and county of all currently contracted Medicaid providers in Colorado

4.7.3.1.1.2. A list of the name and practice address of all physicians who have billed Medicaid at least once in the most recent twelve month period where data is available;

4.7.3.1.1.2.1. This data does not include data protected under the health insurance portability and accountability act (HIPAA).

4.7.3.1.1.3. Ad hoc data will be requested through HCPF's data request review board process.

4.8. Payment for Medicaid funded programs not included the appropriated long bill attachment of this interagency agreement.

4.8.1. Invoices for payment shall be submitted directly to the HCPF designee overseeing management of this Interagency Agreement.

4.8.2. BCCP payment

4.8.2.1. Payment from the prevention, early detection and treatment funds created in section 24-22-117(2)(d)(i), C.R.S. to HCPF for the BCCP established in section 25.5-5-308, C.R.S.

4.8.2.2. The amount of the BCCP payment from DPHE to HCPF shall be the lesser of actual costs for the BCCP or the maximum amount of $1,215,340.00.

4.8.3. Maternal Health Outcomes payment

4.8.3.1. HCPF will pay DPHE for services performed, from available state funds in an amount not to exceed $10,000 beginning in FY 2012-13

4.8.3.1.1. DPHE shall bill HCPF annually for maternal health outcomes services performed

## 5. HEALTH FACILITIES EMERGENCY MEDICAL SERVICES: SURVEY AND CERTIFICATION

5.1. Medicaid provider Surveys and Certifications covered in this Interagency Agreement include the following services as defined in Medicaid regulations:

5.1.1. Alternative Care Facilities (ACFs)

5.1.2. Psychiatric Residential Treatment Facilities

5.1.3. Nursing Care Facilities

5.1.4. ICFs/IIDs

5.1.5. Home Health Agencies (HHA)

5.1.6. Private Duty Nursing (PDN)

5.1.7. Hospice Agencies

5.1.8. Other Services as shown in the following table:

| Waiver | Service |
|---|---|
| Home and Community Based Services (HCBS) Brain Injury (BI) | - Brain Injury Supported Living Program<br>- Transitional Living<br>- Day Treatment<br>- Adult Day<br>- Home Care Agency (HCA) - Personal Care, Homemaker, In-Home Respite |
| Children's HCBS | - Home Care Agency HCA – In-Home Services and Supports (IHSS) |
| Children with Autism (CWA) | - Behavior Therapies (Lead, Senior, Line) |
| Community Mental Health Supports (CMHS) | - Adult Day<br>- Day Treatment |

| Waiver | Service |
|---|---|
| | - Home Care Agency (HCA)<br>- HCA – Personal Care, Homemaker Services |
| Children with Life Limiting Illness (CLLI) | • Respite<br>• Expressive Therapy<br>• Massage Therapy<br>• Palliative and Supportive Care<br>• Therapeutic and Life Limiting Illness Support<br>• Bereavement Counseling |
| Elderly, Blind & Disabled (EBD) | - Adult Day<br>- Day Treatment<br>- Home Care Agency (HCA) – In-Home Services and Supports (IHSS)<br>- HCA – Personal Care, Homemaker Services, In-home respite |
| Spinal Cord Injury (SCI) | - Adult Day<br>- HCA – IHSS<br>- HCA – Personal Care, In-home Respite, Homemaker Services<br>- Alternative Therapies |
| Colorado Choice Transitions *(This is not a waiver program; it is a "Money Follows the Person (MFP) Initiative)* | - Community Transition Services |
| HCBS – Children's Extensive Services (CES) | - Assistive Technology<br>- Behavioral Supports<br>- Community Connector<br>- Dental Services<br>- Home Accessibility Adaptations<br>- Homemaker Services<br>- Personal Care<br>- Professional Services – Hippotherapy<br>- Professional Services – Massage Therapy<br>- Professional Services – Movement Therapy<br>- Respite Services<br>- Vehicle Modifications<br>- Vision Services |
| HCBS – Persons with Developmental Disabilities (DD) | - Behavioral Supports<br>- Dental Services<br>- Individual Residential Services and Supports (IRSS)<br>- Group Residential Services and Supports (GRSS) |

| Waiver | Service |
|---|---|
| | - Non-Medical Transportation<br>- Prevocational Services<br>- Specialized Habilitation<br>- Supported Community Connections<br>- Supported Employment<br>- Vision Services |
| HCBS – Supported Living Services (SLS) | - Assistive Technology<br>- Behavioral Supports<br>- Dental Services<br>- Home Accessibility Adaptations<br>- Homemaker Services<br>- Mentorship<br>- Non-Medical Transportation<br>- Personal Care<br>- Personal Emergency Response System<br>- Prevocational Services<br>- Professional Services - Hippotherapy<br>- Professional Services – Massage Therapy<br>- Professional Services – Movement Therapy<br>- Respite Services<br>- Supported Employment<br>- Vehicle Modifications<br>- Vision Services |

5.2. General Provisions

5.2.1. Priorities and Workload

5.2.1.1. Where applicable, priority of survey and certification shall be given to existing providers and new providers in underserved areas.

5.2.1.2. Changes to the number and frequency of surveys and/or the number and types of programs to be surveyed that could result in changes in costs shall not be made without the express written approval of both departments. Additional resource needs due to workload increases significantly greater than the workload existing on the date this agreement is executed shall be resolved prior to implementation.

5.2.1.3. The parties shall work collaboratively and meet by April 1 of each year to both review the prioritization of activities to be performed pursuant to this agreement, and to resolve any additional resource needs resulting from proposed priority changes.

5.2.1.4. HCPF shall provide DPHE with a copy of the relevant Health Care Policy and Financing Legislative Implementation Plan upon approval. The relevant fiscal officers from the HCPF and DPHE shall notify each other within 2 business days of receipt of a fiscal note request for a bill that affects any DPHE program covered under the terms of this Agreement.

5.2.1.5. DPHE shall participate in scheduled meetings with the Department to review/monitor activities, problems, procedures, and priorities.

5.2.1.6. DPHE shall incorporate educational programs into DPHE activities, to the extent of available appropriations, and resources, in accordance with state guidelines and, if applicable, federal guidelines. The purpose of these programs shall be to provide information and guidance to facility, provider, and ombudsman personnel related to regulatory activities.

5.2.1.7. DPHE shall notify HCPF of updates of the interpretive guidelines, including the state operations manual for nursing facility Surveys, for all applicable Medicaid programs and of CMS conference calls concerning updates and changes in the Survey processes.

5.2.1.8. DPHE shall make available to HCPF upon request any mission letters or other directives, laws or guidelines provided by CMS Survey and Certification that impact the survey priorities, timelines, or scope of the Medicaid providers surveyed herein.

5.2.1.9. HCPF shall inform DPHE of any updates, additions or changes in statute, waiver, regulation or guidance for all applicable Medicaid programs before implementation. Where relevant, DPHE shall inform HCPF of such updates, additions or changes. Both Departments shall solicit input from each other about proposed regulations initiated within their respective agencies that affect Medicaid programs before the regulations are posted for public comment.

5.2.1.10. By December 31, 2015, HCPF and DPHE shall agree to a standardized application process for Medicaid certification that includes a single entry point for providers.

5.2.2. Certification

5.2.2.1. DPHE Responsibilities

5.2.2.1.1. Intent to Change Ownership. DPHE shall send a copy of the provider's letter of intent or otherwise notify the Department in writing of any proposed changes in the ownership of a provider covered by this interagency agreement within 10 business days of DPHE's receipt of the information.

5.2.2.1.2. Intent to Terminate Medicaid Participation. DPHE shall notify the Department within 10 business days of notice that any provider of Medicaid services plans to end Medicaid participation.

5.2.2.1.3. Change of Address, Ownership, and Medicaid Participation. DPHE shall notify the Department in writing within 10 business days of learning that any provider of Medicaid services has terminated its Medicaid provider enrollment or has changed address or ownership.

5.2.2.1.4. Certification and Transmittal. DPHE shall provide Certification and Transmittal (C&T) forms to the Department. Certification and Transmittals shall be submitted to HCPF on an agreed form and by an agreed frequency.

5.2.2.1.5. Recommendation to Certify. DPHE shall notify the Department of its recommendation to certify a Medicaid provider in writing within ten (10) business days of making the recommendation.

5.2.2.1.6. Adverse Actions/Recommendations to Terminate. DPHE shall notify the Department in advance if possible or no later than 2 business days of:

5.2.2.1.6.1. A denial, revocation or of an imposition of conditions on a license.

5.2.2.1.6.2. Recommending to CMS the immediate imposition of an enforcement action against a provider.

5.2.2.1.6.3. Notification from CMS of a denial or termination of Medicare Certification.

5.2.2.1.6.4. A decision to recommend termination of Medicaid Certification.

5.2.2.1.7. Medicare Survey Information. DPHE shall make copies of the Medicare notice of enrollment, statements of Deficiencies, plans of correction, revisit information, and ownership disclosure forms available to the Department once the initial Medicare survey is completed.

5.2.2.1.8. ASPEN Access. DPHE shall make available via Department electronic access to ASPEN and the DPHE web site the following: statements of deficiencies that note when repeat deficiencies were cited, since and including the last Standard Survey; complaint reports (if any), accepted plans of correction; and revisit information. ASPEN shall be made available to at least 10 separate Department computer sites. Data Access. DPHE shall make available via Department electronic access the following data: statements of deficiencies with plans of corrections for initial surveys, cyclical surveys, revisits and complaint investigations. Electronic access shall be provided to a sufficient number of employees, as requested by the Department.

5.2.2.2. HCPF Responsibilities

5.2.2.2.1. Certification Decision. The Department shall make the decision regarding Medicaid Certification of new providers, termination of existing providers, and Change of Ownership.

5.2.2.2.2. Decision to Certify. The Department shall notify DPHE in writing of the status of its Certification decision within 10 business days of its decision to implement the DPHE recommendation of new Certifications. Continuing Certification will be assumed in the absence of termination of Certification notice.

5.2.2.2.3. Change of Address, Ownership, and Medicaid Participation. The Department shall notify DPHE in writing within 10 business days of learning that any provider of Medicaid services has terminated its Medicaid provider enrollment or has changed address or ownership.

5.2.2.2.4. Intent to Terminate Medicaid Participation. The Department shall notify DPHE within 10 business days of learning that any provider of Medicaid services plans to end Medicaid participation.

5.2.2.2.5. Adverse Actions and Decisions to Terminate. The Department shall notify DPHE in advance if possible, or no later than two (2) business days after taking an adverse certification action against a Medicaid provider under this agreement that could affect the resources or way in which a provider has the ability to maintain appropriate care and services to its clients such as termination, significant denial or withholding of payments.

5.2.2.2.6. Provisional Certifications. In advance if possible, or no later than two (2) business days after issuing the provisional certification, the Department shall notify DPHE of provisional certifications for new providers and of provisions that have implications for the survey and certification responsibilities for new and existing providers. To ensure that the provider lists between the two agencies are reconciled, the Department shall provide a list of new providers for whom it has granted provisional certifications within the last fiscal year to DPHE by August 15, 2015.

5.2.2.3. Joint Responsibilities

5.2.2.3.1. DPHE and HCPF shall work collaboratively with the appeals process on adverse determinations for Medicaid providers covered by the terms of this agreement.

5.2.3. Recertification

5.2.3.1. DPHE shall conduct continuing certification of providers enrolled in Medicaid.

5.2.4. Onsite and Post Survey Responsibilities

5.2.4.1. Conducting Surveys. DPHE shall conduct a Certification Survey for Medicaid providers in accordance with applicable federal and state statutes, regulations, and/or procedures. DPHE shall conduct surveys of sufficient scope, duration, and frequency to determine that Medicaid providers specified in this agreement have met necessary federal and state regulatory requirements.

5.2.4.2. Survey Interval. For provider types subject to Medicaid waiver or Medicare certification, the Survey interval shall be based on Medicaid waiver and Medicare requirements. For provider types not subject to Medicare certification, the survey interval shall be as approved in the Medicaid State Plan or Waiver Agreement, but no greater than 36.9 months. DPHE shall prioritize scheduling of continuing Certification Surveys based on its review of complaints and previous Surveys. Providers with past or present Deficiencies, which impact direct client care and/or which meet criteria identified in the Medicaid State Plan or Waiver Agreement, and as agreed upon by the Department and DPHE for prioritizing Survey workload shall be surveyed sooner in the Certification cycle.

5.2.4.3. Deficiency list. Upon completion of each Medicaid Provider Survey, DPHE shall prepare a written statement of Deficiencies identifying any standards the provider failed to meet. The written statement of Deficiencies shall be entered into the CMS Automated Survey Processing Environment (ASPEN) system. Provider plans of

correction shall be made available to HCPF upon request in a format agreed upon by the agencies.

5.2.4.4. Referrals to other agencies/licensing boards. When required or deemed appropriate, DPHE shall refer findings made during Survey activities to other agencies and licensing boards, including, but not limited to, the Colorado Medicaid Fraud Control Unit.

5.2.4.5. Informal Dispute Resolution. DPHE shall conduct an Informal Dispute Resolution (IDR) review consistent with its policies, procedures and federal guidelines, when requested timely by the provider following a survey.

5.2.4.5.1. If Deficiencies are deleted or scope and/or severity are reduced as part of a review process after the survey is finalized, such changes shall be documented. The documentation shall identify the group or staff member who made the decision to change the Deficiency and state the reasons for the change.

5.2.4.5.2. DPHE shall provide the Department with a copy of the letter outlining the IDR findings that is sent to a facility or program provider.

5.2.4.6. Recommending Enforcement Actions. DPHE shall recommend enforcement actions against providers who are found to be in violation of federal Certification standards, pursuant to federal and state statutes and applicable regulations.

5.2.5. Complaints

5.2.5.1. DPHE shall provide a method to receive complaints regarding Medicaid providers specified in this agreement.

5.2.5.2. DPHE shall maintain information on its website as to how complaints may be filed.

5.2.5.3. Complaint investigations shall be conducted in the following manner:

5.2.5.3.1. Upon receipt of a verbal or written complaint regarding a certified Medicaid provider, DPHE shall follow applicable state and federal requirements and time frames with respect to investigating the complaint. Where no state or federal requirements are applicable, DPHE shall prioritize the complaint based on professional judgment, and DPHE policy, and procedure developed in conjunction with the Department. The Department shall notify DPHE in writing within one business day of becoming aware of an alleged Immediate Jeopardy.

5.2.5.3.2. When a complainant submits multiple allegations, a single record may be established to document the complaint. However, each individual allegation shall be reported and resolved separately within that record. For all complaints, DPHE shall contact as appropriate, based on professional judgment, and DPHE policy and procedure, the client and/or the complainant, provider staff, and any other parties who were involved or who may have information regarding the complaint.

5.2.6. Occurrences

5.2.6.1. DPHE shall respond to occurrences reported by licensed providers consistent with statute and DPHE policies and procedures.

5.3. Nursing Care Facilities

5.3.1. Survey. DPHE shall conduct a Certification Survey for Medicaid providers

5.3.1.1. PASRR Review. During the survey process DPHE shall determine whether residents in the phase one sample, or phase two sample, if applicable had the following:

5.3.1.1.1. A comprehensive PASRR Level I and Level II assessment,

5.3.1.1.2. An appropriate care plan, and

5.3.1.1.3. Specialized services, if required based on the PASRR review.

5.3.2. Provider Forum. DPHE shall provide a forum for Medicaid providers, through regular long term care advisory committee meetings for the exchange of information regarding the survey, Certification, related regulatory processes, and proposed changes to these processes.

5.3.3. Hospital Backup Level of Care Program

5.3.3.1. To provide Hospital Backup Level of Care, the nursing facility shall be determined by DPHE to be in substantial compliance with federal regulations regarding direct patient care and HCPF regulations for HBU conditions of participation. DPHE shall provide the following information: Certification information from the most recent Standard Survey report, information from the complaints history, and a recommendation to the Department stating whether or not a particular nursing facility may be used to place patients being considered for the Hospital Backup Level of Care Program.

5.4. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

5.4.1. Survey. DPHE shall conduct a Certification survey for all Medicaid providers.

5.5. Hospices

5.5.1. Survey. DPHE shall conduct a Certification Survey for all Medicaid providers following Medicare survey procedures.

5.6. Home Health Agencies (HHAs)

5.6.1. Survey. DPHE shall conduct a Certification Survey for all Medicaid providers.

5.6.2. Provider Meeting Site. DPHE shall provide a meeting site for Medicaid providers, through the quarterly Home Health Information Exchange meetings, for the exchange of information regarding the survey and Certification and related regulatory processes and for proposed changes to these processes.

5.7. Private Duty Nursing (PDN)

5.7.1. Survey. DPHE shall ensure the specific inclusion of such special program clients in the initial or re-Certification Survey sample for home visits and/or record reviews during

the survey for all agencies providing Medicaid Home Health Services to clients enrolled in the PDN program.

5.7.2. Record Reviews and Home Visits. DPHE shall conduct record reviews and home visits to Medicaid clients as requested by the Department in accordance with Medicare COP regulations. DPHE shall monitor specific Medicaid clients'/patients' PDN cases within the course of a Survey or complaint investigation.

5.7.3. Client Lists. The department shall provide a monthly list of clients receiving services under the PDN program including the name of the agency providing services.

5.7.4. Participation Recommendations. DPHE shall make recommendations to the Department regarding the participation of PDN service providers.

5.8. Alternative Care Facilities (ACFs)

5.8.1. Survey. DPHE shall conduct a Certification Survey for all Medicaid providers according to survey protocols developed and mutually agreed upon by both parties.

5.8.2. Provider Forum. DPHE shall provide a forum for Medicaid providers, through regular advisory committee meetings for the exchange of information regarding the Survey, Certification, related regulatory processes, and proposed changes to these processes.

5.9. Psychiatric Residential Treatment Facilities

5.9.1. Survey. DPHE shall conduct a certification survey in accordance with Medicare requirements.

5.10. Other Services as listed under section 5.1.8.

5.10.1. Survey. DPHE shall conduct a Certification survey according to survey protocols developed and mutually agreed upon for providers listed under Section 5.1.8.

5.10.2. Use of Risk Based Survey Schedule. An HCBS provider shall have at minimum a three-year history of Surveys in order to establish eligibility for a Risk-Based Survey Schedule. The Risk-Based schedule protocols shall be jointly developed in accordance with state and federal law and shall be written by the Department and DPHE.

5.10.3. Application Packets. DPHE shall supply, upon request from potential HCBS providers, complete application packets for the specified HCBS provider specialty.

5.10.4. For HCBS CES, DD, & SLS Waivers, DPHE agrees to continue to conduct the responsibilities of the transferred staff related to the Critical Incident Reporting System (CIRS) until an alternative is identified and mutually agreed upon by HCPF and DPHE. By December 31, 2015, HCPF and DPHE shall develop an implementation plan for the alternative.

5.11. REPORTS

5.11.1. Nursing Care Facilities including Hospital Back Up

5.11.1.1. Licensed nursing facility census reports. Quarterly nursing facility census due within 70 days of quarter's end. There are two versions of this report: by nursing facility name and by county. The reports shall only include census for nursing

facilities reported timely. The reports include totals by Medicare, Medicaid, and other categories and percentage of bed capacity.

5.11.1.2. Nursing facilities Medicaid bed report for open facilities. Reconciled authorized Medicaid bed count of Medicare and certified Medicaid beds in nursing facilities on a quarterly basis.

5.11.1.3. Monthly survey summary report. Monthly list of the surveys completed, survey type, and survey findings for providers.

5.11.1.4. Open Nursing facilities (long term care demographic report). Quarterly report of nursing facilities, including name, address, phone number, fax number, administrator name, and Medicare/Medicaid number.

5.11.1.5. Monthly complaint list for Medicaid facilities which includes the provider involved, source of referral, mode of complaint, date complaint received, date complaint assigned, dates investigation started and ended, date report completed, investigator, allegations, and findings.

5.11.1.6. Monthly complaint summary for Medicaid facilities which includes the number of complaints, allegation type, number of substantiated/non-substantiated complaints, and number of Deficiencies.

5.11.1.7. Scope and severity analysis. Quarterly scope and severity analysis for nursing facilities for standard (initial and re-Certification) and complaint surveys.

5.11.1.8. Monthly summary of licensed Medicaid facility Occurrences.

5.11.1.9. Minimum data set (MDS) resident assessment instrument data extract for case mix rate setting.

5.11.2. ICF/IID Reports and Data

5.11.2.1. Monthly survey summary report. Monthly list of the surveys completed, survey type, and survey findings for providers.

5.11.2.2. Monthly summary of licensed Medicaid facility Occurrences.

5.11.2.3. Monthly complaint summary for facilities which includes the number of complaints, allegation type, result of investigation, provider involved, number of substantiated/non-substantiated complaints, and source of referral.

5.11.2.4. Monthly complaint list for Medicaid facilities which includes the provider involved, source of referral, mode of complaint, date complaint received, date complaint assigned, dates investigation started and ended, date report completed, investigator, allegations, and findings.

5.11.2.5. Quarterly report of open ICFs/IIDs, including name, address, phone number, fax number, administrator name, and Medicaid number.

5.11.2.6. Medicaid bed report for open ICF/IID facilities. Reconciled authorized Medicaid bed count of certified Medicaid beds in ICF/IIDs on a quarterly basis.

5.11.3. Hospices:

5.11.3.1. Monthly summary of licensed Medicaid facility occurrences.

5.11.3.2. Monthly survey summary report. Monthly list of the surveys completed, survey type, and survey findings.

5.11.3.3. Monthly complaint list for Medicaid Hospices which includes the provider involved, source of referral, mode of complaint, date complaint received, date complaint assigned, dates investigation started and ended, date report completed, investigator, allegations, and findings.

5.11.3.4. Monthly complaint summary for Medicaid Hospices which includes the number of complaints, allegation type, number of substantiated/non-substantiated complaints, and number of Deficiencies.

5.11.3.5. Monthly new Hospice report listing initial Licensure surveys for Hospice.

5.11.3.6. Written notification to a provider of Immediate Jeopardy situations and Condition level Deficiencies for Hospice shall be sent to the Department on an ongoing and as processed basis.

5.11.4. HHAs:

5.11.4.1. Monthly survey summary report. Monthly list of the surveys completed, survey type, and survey findings.

5.11.4.2. Monthly complaint list for Medicaid Home Health Agencies which includes the provider involved, source of referral, mode of complaint, date complaint received, date complaint assigned, dates investigation started and ended, date report completed, investigator, allegations, and findings.

5.11.4.3. Monthly complaint summary for Medicaid Home Health Agencies which includes the number of complaints, allegation type, number of substantiated/non-substantiated complaints, and number of Deficiencies.

5.11.4.4. List of Medicaid complaints. Annually or as requested Home Health complaint report from hot line (referral source; type of complaint; investigated or not; if not investigated, reason; number of days to resolve complaint).

5.11.4.5. Annual report of all Home Health Agencies that had Deficiencies cited, including Deficiencies cited for each.

5.11.4.5.1. Condition level Deficiencies for the Home Health Agency program will be sent to the Department on an ongoing and as processed basis.

5.11.5. ACFs:

5.11.5.1. Monthly summary of licensed Medicaid facility Occurrences Report.

5.11.5.2. Monthly survey summary report. Monthly list of the Surveys completed, Survey type, and Survey findings.

5.11.5.3. Monthly complaint list for ACFs which includes the provider involved, source of referral, mode of complaint, date complaint received, date complaint assigned,

dates investigation started and ended, date report completed, investigator, allegations, and findings.

5.11.5.4. Monthly complaint summary for ACFs which includes the number of complaints, allegation type, number of substantiated/non-substantiated complaints, and number of Deficiencies.

5.11.5.5. Open facility report. List provided monthly of licensed assisted living residences and certified ACFs by county.

5.11.5.6. The Department shall provide the following ACF reports to DPHE:

5.11.5.6.1. A table report indicating the number of Medicaid paid days for each ACF for the prior fiscal year by February 15 of each year. DPHE shall use this information to determine "high" Medicaid utilization ACFs, for the purpose of setting licensing fees.

5.11.6. Other Services listed under 5.1.8.

5.11.6.1. Monthly survey summary report, which lists surveys completed in the month, survey type, and survey findings.

5.11.6.2. Monthly complaint list, which includes the provider involved, source of referral, mode of complaint, date complaint received, date complaint assigned, dates investigation started and ended, date report completed, investigator, allegations, and findings.

5.11.6.3. Monthly complaint summary, which includes the number of complaints, allegation type, number of substantiated/non-substantiated complaints, and number of Deficiencies.

5.11.6.4. Monthly open facility report sorted by county.

5.11.6.5. Annual 372 Reports for services listed under section 5.1.8 and ACFs.

5.11.6.5.1. By November 1, By November 1, DPHE shall provide reports to the Department with the following information for the previous fiscal year (July 1 – June 30): the number of agencies out of the total number of surveyed that were cited for deficiencies, type of deficiencies and descriptions listed in descending order of frequency.

5.11.6.5.2. By May 1, DPHE shall provide reports to the Department with the following information for the previous calendar year (January 1 – December 31):

5.11.6.5.2.1. Number of HCBS providers out of the total number surveyed who were cited for Deficiencies and the number who were terminated for failure to correct Deficiencies.