COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Site Review Report

for

Colorado Access

Region 3

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This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposals 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The Regional Accountable Entities (RAEs) are responsible for integrating the administration of physical and behavioral healthcare and will manage networks of fee-for-service (FFS) primary care providers (PCPs) and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCMs and PIHPs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCMs and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2018–2019 site review activities for **Colorado Access Region 3** (**COA R3**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2018–2019 compliance monitoring site review. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the care coordination record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2018–2019 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol. Appendix F includes the summary of the focus topic interviews with RAE staff members used to gather information for assessment of statewide trends related to the 2018–2019 focus topic selected by the Department.

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **COA R3** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	12	11	11	0	0	1	100%
IV. Member Rights and Protections	7	7	7	0	0	0	100%
V. Member Information	19	17	16	1	0	2	94%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	7	1	0	0	88%
Totals	**46**	**43**	**41**	**2**	**0**	**3**	**95%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

COA's Care Coordination policy provided a comprehensive overview of the care coordination program addressing all required components applicable to high-risk or complex needs members. Care coordination teams were organized according to areas of expertise—e.g., behavioral health (BH), physical health (PH), criminal justice, long-term care, community-based (e.g., social support), pediatric care, and adolescent care. In addition, **COA** had embedded care coordinators in the Denver Health emergency department, Colorado Mental Health Institute at Fort Logan, and Aurora Mental Health Center. Additional documents—transition of care workflows and continuity of care policies—indicated that care coordination for RAE members was heavily focused on transitions of care between settings; transition of care teams were aligned with specific hospital facilities. **COA** used admit, discharge, and transfer data from Colorado Regional Health Information Organization (CORHIO) as well as utilization management (UM) authorization requests for high-level services to identify members in need of transition of care services. Providers, community partners, and agencies—e.g., Department of Corrections and parole boards, Departments of Human Services, hospital discharge planners, and other sources also identified and referred high-risk members to care management. **COA** has adopted the four-quadrant model for stratifying members into care coordination intervention categories and has in development a data-driven stratification model using diagnostic cost group (DCG) data from the Truven Health system and BH claims data to assign each member to a risk quadrant. **COA** care navigators telephonically outreached members assigned to lower risk categories or with less complex needs—including those identified through the Department's health needs assessment (HNA)—to further screen member needs, provide resources, or refer to care managers for follow-up. Care managers performed an individual comprehensive needs assessment with each high-risk member identified to care management to determine specific medical, behavioral, social support, financial, cultural, and other needs; and developed a care plan with member-oriented goals and interventions. Care managers engaged face to face with members transitioning from acute care facilities or receiving services in facilities with an embedded **COA** care coordinator. BH care managers and care navigators conducted telephonic care coordination with members. The **COA** care manager initially assigned to the member assumed the lead coordinator position unless member needs were associated with a specialized care coordination team better suited to the member's primary needs or agreement was reached with an external agency's care manager to assume the lead role. All care coordination activities—e.g., assessments, care plan, and interventions—were documented in **COA**'s Altruista Guiding Care system, which met all required elements of an electronic care coordination tool.

While the Department assigned each member to a primary care medical provider (PCMP) upon enrollment and informed the member of his or her PCMP, **COA** also assisted members who contacted customer services to connect them with a behavioral health provider or to change the assigned PCMP. In addition, a primary objective of care coordination for both PH and BH transitions of care was to establish the member with an appropriate provider following discharge. Care managers informed members with whom they were involved, either via telephone communications or by providing a personal business card during face-to-face encounters, of how to contact the care manager.

The **COA** provider manual described that the PCMP was responsible for coordinating care and making referrals for each member. PCMPs could refer members with higher-level coordination of care needs to **COA**'s care management program. In addition, **COA** had designated 15 PCMP entities—serving approximately 40 to 50 percent of the total RAE populations in Regions 3 and 5—as enhanced clinical partners (ECPs). ECPs are responsible for providing a higher level of care coordination for members within their practice, including short-term referrals to medical and social-service communities, and developing and administering long-term member care plans for members with complex needs. **COA**'s practice transformation team works with ECPs to enhance internal care coordination capabilities and resources. In addition, **COA** facilitated and expected PCMPs to develop and increase the number of care compacts between the PCMP and specialists. **COA**'s care management processes addressed care coordination between settings of care, particularly discharge planning from institutional stays, members transitioning between RAEs, and coordinating with services received from FFS providers. Member assessments identified services that members were receiving from community and social support providers. Care coordinators shared with other entities involved with the member the results of assessments, planned interventions, and facilitated exchange of information among providers. Members' privacy in the process of coordinating care was protected through extensive processes outlined in confidentiality policies and procedures and through secure information exchanges. For all members receiving behavioral health services, the provider manual outlined provider responsibilities for conducting an intake assessment and developing a service plan based on the assessment. The provider manual also outlined the required components of the individual member medical record for both the BH providers and PCMPs. **COA** submitted a comprehensive audit tool used in annual audits of provider medical records to confirm that all required medical record elements were accurately addressed. Providers were required to maintain confidentiality of member information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

Summary of Findings Resulting in Opportunities for Improvement

COA's Care Coordination policy outlined at a high-level a comprehensive program for care coordination; however, the policy lacked procedures for implementation, necessitating extensive on-site discussion to delineate how the program is organized and implemented. HSAG recommends that **COA** more specifically define documented procedures for implementing the care management program—e.g., organizational model, teams, stratification, assessments—and outline responsibilities, accountabilities, and detailed processes related to all components of its multifaceted program.

Documentation, on-site interviews, and some care coordination case presentations demonstrated that **COA** has processes to coordinate care: for members transitioning between settings of care; for members transitioning between RAEs; with external agencies and community organizations; and with FFS physical health providers. However, HSAG noted that particular emphasis was placed on coordinating care with members transitioning from institutional settings and that these processes were oriented to ensuring that each member had and maintained follow-up appointments with BH providers or PCMPs as applicable. In addition, HSAG observed in several care coordination presentations that **COA**'s organization model of specialized care coordination teams—e.g., transition of care teams; behavioral health teams, criminal-justice transition team, the single entry point (SEP), and others—might result in

the following vulnerabilities: referring members with complex needs to various care coordination teams during engagement with the member rather than maintaining a consistent lead coordinator throughout; or prematurely closing a case when the goals of a specific team—e.g., transitions of care—were realized, even when ongoing additional member needs were apparent. HSAG observed that **COA**'s organizational model and procedures could potentially result in gaps in needed services and/or fail to create a seamless experience for members and providers. HSAG encourages **COA** to ensure that mechanisms exist for smooth transition from one care coordination team to another and/or maintain a consistent care coordinator contact for ongoing monitoring of members with complex needs.

During on-site interviews, staff members stated that results of member needs assessments were communicated to providers and other entities primarily through verbal contacts between care managers and other entities involved in the member's care. HSAG recommends that **COA** consider, to prevent duplication of these efforts, enhancing this process to include written communication of the full member assessment of identified needs.

The **COA** provider manual stated that providers will coordinate care for members and maintain adequate medical records, and delineated assessment and treatment plan components. However, neither the provider manual nor other documents clearly communicated the responsibility of BH providers to *share* the member health record as appropriate. HSAG recommends that **COA** enhance its provider communications to emphasize the need to share member records with other entities providing services to the member, possibly through member releases of information (ROIs) and/or delineating those aspects of the BH record that are not precluded, by member privacy laws, from being shared with appropriate entities.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

The **COA** Member Rights and Responsibilities policy included the full list of rights afforded members under 42 CFR 438.100. In addition, **COA** maintained policies to address member rights under other applicable laws and regulations. Examples included policies to address anti-discrimination, equal access for members with disabilities, advance directives, and privacy and confidentiality guaranteed under HIPAA. The policy that addressed rights for members with disabilities described use of an Americans with Disabilities Act (ADA) coordinator to ensure that auxiliary aids and services are provided when needed. The policy that addressed development of member communication materials described processes to ensure that materials are easily understood and readily accessible. Related to medical records and other member-identifiable information, HIPAA policies addressed access to protected health

information (PHI) use, disclosure, minimum necessary requirements, encryption, transmission, electronic storage, paper storage, disposal, and handling suspected breaches.

COA's policies addressed communication channels to ensure that members and providers are aware of members' rights and that both members and providers are aware that neither providers nor the RAE are permitted to retaliate in any way against members who exercise those rights. On-site, RAE staff members confirmed that information in policies was communicated to members and providers through mechanisms such as staff and provider training, communication with members through newsletters, topic-specific mailings, and the member advisory council. RAE staff members also described ongoing auditing and monitoring to detect compliance issues that may impact member rights, and methods to address and mitigate any issues identified.

Summary of Findings Resulting in Opportunities for Improvement

The RAE's provider manual introduced the subject of member rights and included a link to the member page of the website that listed the member rights delineated at 42 CFR 438.100. The provider manual included a complete description of members' rights to file grievances and appeals, and another link opened the page where grievance and appeal forms could be obtained. The advance directives section included comprehensive information and included a link to the State's information regarding advance directive laws and forms. Neither this section of the provider manual nor the "Provider Responsibilities" section actually described providers' responsibilities related to member rights. **COA** may want to consider including brief statements regarding providers' responsibilities to observe and protect member rights and how to report member rights concerns.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

HSAG found that **COA** has robust processes for testing member materials for sixth grade readability and to ensure that specific documents available electronically on the **COA** website are machine readable and comply with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. On-site, the RAE staff member responsible for these processes demonstrated the tools used for testing. HSAG found that member materials provided for review (new member and annual information packets and member-specific communications related to grievance and appeal processing) were easily understood and compliant with Section 508 guidelines. **COA** also provided evidence that member materials had been reviewed by its member advisory council.

COA's new member packet, annual member mailing, and information found on the RAE's website (including videos) were clear and designed to help members understand the requirements and services offered under the State Medicaid benefit plans. The new member packet and annual member mailing included links to the Department's website for members to access the Health First Colorado (HFC) member handbook. During on-site interviews, staff members described ongoing topic-specific written communications and interactive voice response (IVR) calls to members to assist members in understanding preventive and routine services available. New member and annual mailings were printed in English and Spanish. All member materials reviewed by HSAG included taglines in English and Spanish and 14 additional languages. Materials were written in 12-point font with taglines in English and Spanish and in 18-point font. **COA** provided evidence of effective processes for providing language line assistance for translation and in-person translations (including sign language) when needed. RAE staff members described provision of materials in other formats when needed, including Braille and audio formats.

COA's website included all required information either through direct description or through links to pages within the website or links to the State's website (e.g., HFC member handbook and State laws related to advance directives). **COA**'s website description of the general functions of the RAE clearly and effectively defined the Accountable Care Collaborative (ACC) program.

The RAE provider directory included the required information about providers. Staff members reported that providers were listed as having had cultural competency training if the provider obtained the training from either **COA** or the Office of Behavioral Health (OBH). Staff members also reported that disability access (reported as "yes" or "no" in the directory) was self-reported by providers and that **COA** has plans to enhance the provider directory with more robust details related to the type of disability access that provider offices and facilities offer.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

COA's website included clear and concise information about required website elements; however, the section that addressed filing and processing of appeals contained outdated information. **COA** must ensure that information on its website includes updated and correct information regarding appeals procedures.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Summary of Strengths and Findings as Evidence of Compliance

COA provided information to members regarding EPSDT benefits and services on its member website. The website listed specific categories of services available for members ages 20 and under, including specific behavioral health services; and provided links to the Health First Colorado member handbook, the Department's EPSDT fact sheet, a training video for parents, and **COA** care management contact numbers. The EPSDT policy stated that providers are informed of the EPSDT program through the provider manual. The provider manual section, "Behavioral Health Policies and Standards" listed services available through EPSDT, including capitated BH services provided under the EPSDT program. The manual outlined specific expectations of BH providers, including: communicating with the member's PCP, providing appropriate BH screening and treatment services, inquiring whether members have used their EPSDT benefits, and reviewing the Department's EPSDT materials and training webinar—with a link to the Department's website. **COA**'s website—*Provider Resources and Trainings*—outlined similar information for providers in addition to describing UM and prior-authorization request (PAR) processes for EPSDT services. Staff members provided evidence that the Department's EPSDT training webinar was also provided to UM and care management staff. Staff members stated that EPSDT updates would be provided via provider newsletters, provider quarterly forums, or the soon-to-be-implemented provider portal.

The provider manual outlined all elements of RAE contract requirements related to provision of EPSDT behavioral and mental health screenings and appropriate treatment by BH providers. The EPSDT policy stated that care coordination staff would assist with referrals for treatment not covered by the RAE, provide assistance with transportation and scheduling appointments, and utilize State agencies and programs listed in RAE contract requirements. The EPSDT policy also stated that the RAE arranges for provision of services as listed in the required BH service benefits—e.g., vocational services, prevention/early intervention services, drop-in center, residential treatment, recovery services, and respite services. **COA** demonstrated tracking the utilization of these services by EPSDT-eligible members.

The EPSDT policy and the provider manual stated that **COA** care coordination services were available to assist providers in resolving barriers related to EPSDT benefits, and referred providers to Healthy Communities for Region 3 and Region 5 counties. HSAG observed through on-site care coordination presentations several cases in which care coordinators assisted members with access to needed EPSDT-eligible services, including participation in the Department's Creative Solutions meetings. Care coordinators were also notified by UM to follow up with members to provide additional community or agency referrals when EPSDT-eligible services were denied authorization by **COA**. Staff members stated that **COA**'s care coordination staff included EPSDT subject-matter experts. The EPSDT policy accurately defined medical necessity criteria for BH services and stated that prior authorization for respite and residential treatment services were reviewed and denied using standard review procedures. Members and providers were notified through the UM notice of adverse benefit determination that the

member may be eligible for services through other resources in the Medicaid system. UM also contacted the member's provider to suggest that the provider submit a PAR to the Department.

COA submitted a Tri-County Health Department (TCHD) Healthy Communities memorandum of understanding (MOU) and scope of work (SOW) documenting the commitment of **COA** and TCHD to work together to develop an onboarding plan for newly enrolled Medicaid members. The SOW defined a two-year formal planning process addressing a variety of collaborative activities as well as developing implementation plans and operationalizing exchange of information. Staff members stated that the planning process was being conducted collectively between Regions 3 and 5 and both Tri-County and Denver County Healthy Communities contractors. Participants were meeting bi-monthly and anticipated meeting monthly in the future. Staff members stated that prior to completion of the onboarding plan, **COA** continues to refer members and providers to Healthy Communities for assistance in accessing services and has developed a form to be used when coordinating care for individual members who are shared RAE and Tri-County Healthy Communities clients.

Summary of Findings Resulting in Opportunities for Improvement

While **COA** informed members of EPSDT benefits through its member website, HSAG observed that **COA** had no mechanism to alert members that EPSDT information could be accessed through the website. HSAG also noted several opportunities for improvement in the information provided on the website, including: informing members that well-child visits and screening services are provided through the member's PCP and are provided according to a periodic schedule; removing a redundancy in the listing of individual therapy under BH services; and clarifying the statement, "A medically necessary service used to treat a certain diagnosis is covered." HSAG recommends that **COA** review its website for opportunities to improve information and clarity for members, and consider implementing additional member communications regarding EPSDT and/or alert members to access EPSDT information on the **COA** website.

Although EPSDT information in the provider manual and website provider trainings was thorough, comprehensive, and included specific expectations of BH providers, HSAG reminds **COA** to ensure that EPSDT provider updates and/or trainings are offered every six months.

While the EPSDT policy addressed all requirements related to EPSDT, the policy lacked implementation procedures and accountabilities; and other documents submitted as evidence of implementation were only incidentally related to EPSDT requirements. HSAG recommends that **COA** develop or enhance written procedures and staff training related specifically to EPSDT services—e.g., care coordination procedures, UM procedures, and auditing—to ensure that EPSDT services are provided or arranged.

While EPSDT policies outlined the complete and accurate definition of "medical necessity" related to EPSDT services, staff members explained that authorization requirements primarily apply only to inpatient and higher-level BH services (not outpatient services and referrals) and that **COA** considered the standard authorization criteria applied to these services sufficient for reviewing these services for EPSDT-eligible members. HSAG encourages **COA** to ensure that the expanded definitions of "medical

necessity"—e.g., reducing "effects" of an illness, condition, or disability; a course of treatment that includes observation or no treatment at all; provides a safe environment for the child—are recognized and applied by medical reviewers making authorization decisions regarding potential EPSDT-related benefits prior to denying services.

Staff members stated that some components of EPSDT requirements—e.g., culturally-sensitive assessments and care plans, documentation in the child's medical record, performed by a qualified mental health provider—could be monitored through the standard provider medical record audit tool; however, tool instructions included no reference to EPSDT-specific requirements. HSAG recommends that **COA** consider modifications to the medical record audit tool to accommodate periodic targeted assessment of BH provider compliance with EPSDT requirements.

Summary of Required Actions

The Tri-County Health Department Healthy Communities MOU and scope of work (effective December 2018) essentially outlined an agreement for **COA** and Tri-County Healthy Communities to participate in up to a two-year formal planning process that would culminate in a collaborative onboarding plan for children and families in Region 3. As such, **COA** had not yet accomplished creating an onboarding plan in partnership with Healthy Communities. **COA** must expedite the planning and implementation process with the Tri-County Healthy Communities contractor to create an annual plan for onboarding of children and families.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights and Protections; Standard V—Member Information; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards. In addition, the Department requested that HSAG conduct on-site group interviews with key RAE staff members to explore individual RAE experiences related to one focus topic. The focus topic chosen by the Department for 2018–2019 was *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE*.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable.* Due to the July 1, 2018, effectiveness date of the RAE contract, the Department determined that the review period was July 1, 2018, through December 31, 2018. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to RAE care coordination.

HSAG also reviewed a sample of the RAE's administrative records related to RAE care coordination to gain insight into the RAE's processes for coordinating care for members with complex needs. Reviewers used standardized monitoring tools to review records and summarize findings. HSAG used a sample of five records with an oversample of three records (to the extent that a sufficient number existed). HSAG selected the samples from 20 complex care coordination cases that occurred between July 1, 2018, and December 31, 2018, and were identified by the RAE.

To facilitate the focus topic interviews, HSAG used a semi-structured qualitative interview methodology to explore with RAE staff members information pertaining to the Department's interests related to the focus topic selected. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. Focus topic discussions were not scored. HSAG and the Department collaborated to

develop the *Focus Topic Interview Guide* and the coordination of care case summary tool. Appendix F contains the summarized results of the on-site focus topic interviews.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2018–2019 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

The objective of the site review was to provide meaningful information to the Department and the RAE regarding:

- The RAE's compliance with federal healthcare regulations and managed care contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.
- Information related to the specific focus topic area to provide insight into statewide trends, progress, and challenges in implementing the RAE and ACC programs.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2018.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit B1—11.3.1, 11.3.7	**COA RAE-3** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Utilization Management Work Flow_RAE • Coordination and Continuity of Care Overview_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit B1--None	**COA RAE-3** • CCS305 Colorado Access Care Coordination_RAE • COA_RAE Physical Health Transitions of Care Workflow_RAE • COA_RAE Behavioral Health Institutional_TOC Workflow_RAE • The Enrollment Broker mails the member letters that identify the member's PCMP as well as RAE. https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-phase-ii%E2%80%94member-messaging-resource-center#HealthFirstEnrollmentLetters	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 1: Exhibit B1—6.8.1	**COA RAE-3** • Std III Requirement 3_Attribution_RAE	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: COA provided documentation demonstrating having analyzed and identified attribution issues that applied to large numbers of the Medicaid population in Region 3 and that COA was working with the Department to try to resolve large-scale attribution issues prior to implementing processes to conduct follow-up with members to change those members' attributed PCMPs. HSAG agreed that it is premature to involve individual members in attribution re-assignment and therefore scored this element *Not Applicable* pending outcomes of working with the Department to resolve systems issues related to attribution.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit B1—11.3.3.2	**COA RAE-3** • CCS305 Colorado Access Care Coordination_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. Contract Amendment 1: Exhibit B1—14.3	**COA RAE-3** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE • CM DP09 CM Transitions of Care_RAE • Coordination and Continuity of Care Overview_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid.	**COA RAE-3** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE • CM DP09 CM Transitions of Care_RAE • Coordination and Continuity of Care Overview_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit B1—11.3.10, 11.3.5, 10.3.2, 10.3.4		
7. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit B1—7.5.2–3	**COA RAE-3** • CM DP11 Health Needs Assessment Survey_RAE • COA_RAE HNA Workflow_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. *For the Capitated Behavioral Health Benefit:* The RAE ensures: • That each member receives an individual intake and assessment appropriate for the level of care needed. • Use of the information gathered in the member's intake and assessment to build a service plan. • Provision of continuity of care for members who are involved in multiple systems and experience service	**COA RAE-3** • Provider Manual Section 3_RAE • QM302, p. 2, #1 - Quality Review of Provider Medical Records_RAE • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit B1—14.7.1.1-3	• COA_RAE Behavioral Health Work Flow_All Care Settings_RAE	
9. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit B1—None	**COA RAE-3** • CCS305 Colorado Access Care Coordination_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	**COA RAE-3** • COA Provider Manual Section 3_RAE • COA Provider Manual Section 4_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age.	**COA RAE-3** • Std. III_Req_10_Altruista screenshots_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 1: Exhibit B1—15.2.1.1, 15.2.1.3, 15.2.1.4		
12. The RAE ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(6)* Contract: 20.B Amendment 1: Exhibit B1—11.3.7.11, 15.2.1.2.2	**COA RAE-3** • PRI 100 Protecting Member PHI_RAE • PRI 101 Clinical Staff Use and Disclosure of Member PHI_RAE • PRI 103 Authorizations to Disclose Member PHI_RAE • PRI 104 Member Rights and Requests Regarding PHI_RAE • PRI 105 Personal Representatives and Member PHI_RAE • PRI 200 Sanctions Policy_RAE • HIP 204 Security of EPHI_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit B1—7.3.7.1–2	**COA RAE-3** • CS212 Member Rights and Responsibilities_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit B1—7.3.7.3	**COA RAE-3** • CS212 Member Rights and Responsibilities_RAE • Provider Manual Section 2_RAE • See link on COA website: https://www.coaccess.com/members/services/rights/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment.	**COA RAE-3** • CS212 Member Rights and Responsibilities_RAE • ADM208 Member Materials_RAE • COA website: https://www.coaccess.com/members/services/rights/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit B1—7.3.7.2.1–6		
4. The RAE ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit B1—7.3.7.2.7	**COA RAE-3** • ADM203 Member Grievances_RAE • Provider Manual Section 2_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.U	**COA RAE-3** • ADM205 Nondiscrimination_RAE • ADM206 Culturally Sensitive Services for Diverse Populations_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • ADM230 Member Disability Rights Request and Resolution_RAE • MKT201 Printed Marketing/Informational and Corporate Branding Materials_RAE • COA Provider Manual Section 2_RAE • See COA website: https://www.coaccess.com/nondiscrimination/ http://www.coaccess.com/documents/Notice-of-Privacy-Practices.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: 20.A Exhibit A—2.c and 3.a	**COA RAE-3** • PRI 100 Protecting Member PHI_RAE • PRI 101 Clinical Staff Use and Disclosure of Member PHI_RAE • PRI 103 Authorizations to Disclose Member PHI_RAE • PRI 104 Member Rights and Requests Regarding PHI_RAE • PRI 105 Personal Representatives and Member PHI_RAE • PRI 200 Sanctions Policy_RAE • HIP 204 Security of EPHI_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated.	**COA RAE-3** • CCS303 Advance Directives_RAE • Provider Manual Section 2_RAE • Web Site: ○ https://www.coaccess.com/members/services/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives. • Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.1.3–7		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	100%

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 1: Exhibit B1—7.2.5, 7.3.6.1	**COA RAE-3** • ADM206 Culturally Sensitive Services for Diverse Populations_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • MKT DP 03 Accessibility Standards - 508/ADA Compliance_RAE • Minutes from the Member Advisory Council_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit B1—7.3.6.1	**COA RAE-3** • See COA website content and link to HCPF Member Handbook: https://www.coaccess.com/members/care/ • New Member Packet_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 1: Exhibit B1—3.6, 7.3.4	**COA RAE-3** • N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: The Department has not provided a list of these definitions to the RAEs, excepting a few which may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the RAE to be aware of this requirement and to consistently use definitions from the Department when available.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18-point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit B1—7.2.7.3–9; 7.3.13.3	**COA RAE-3** • ADM205 Nondiscrimination_RAE • ADM206 Culturally Sensitive Services for Diverse Populations_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • MKT201 Printed Marketing/Informational and Corporate Branding Materials_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	**COA RAE-3** • MKT203 Website Design Maintenance and Oversight_RAE • MKT DP03 Accessibility Standards 508/ADA Compliance_RAE • See COA website: https://www.coaccess.com/	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The RAE makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: Exhibit B1—None	**COA RAE-3** • See COA website for link, section on physical health: https://www.coaccess.com/members/care/	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The RAE makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services.	**COA RAE-3** • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • CS DP28 Nextalk for TTY_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The RAE notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and informs how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit B1—7.2.6.2–4	• CS DP29 Interpreting Services_RAE • See: https://www.coaccess.com/members/services/ • Voiance MSA with BAA_RAE	
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit B1—7.2.6.1, 7.2.6.5	**COA RAE-3** • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • CS DP29 Interpreting Services_RAE • See COA website and language options at top of page: www.coaccess.com	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit B1--None	**COA RAE-3** • New Member Packet_RAE • BRD for New Member Mailing Lists_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 1: Exhibit B1--None	**COA RAE-3** • ADM328 Significant Changes in Members Rights, Benefits or Processes_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 1: Exhibit B1—7.3.8.1	**COA RAE-3** • ADM208 Member Materials_RAE • New Member Packet_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 1: Exhibit B1—7.3.10.1	**COA RAE-3** • ADM300 Provider Terminations_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit B1—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	**COA RAE-3** • RAE website_Std_V_Requirement 13_RAE	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: COA's website included clear and concise information about the elements outlined in the requirement. The trainings section included both provider trainings and videos designed to assist members in understanding benefits and who to contact for additional information. However, the section that addressed filing and processing appeals contained outdated information.		
Required Actions: COA must ensure that information on its website includes updated and correct information regarding appeals procedures.		
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL,	**COA RAE-3** • See COA Provider directory at: https://coadirectory.info/search-member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit B1—7.3.9.1.6		
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	**COA RAE-3** • See COA provider directory at: https://coadirectory.info/search-member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • RAE's single toll-free customer service phone number. • RAE's email address. • RAE's website address.	**COA RAE-3** • New Member packet_RAE • RAE Materials_Std_V_Req 16_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 1: Exhibit B1—7.3.6.1		
17. The RAE will annually mail each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit B1—7.3.8.1	**COA RAE-3** • Annual DOI mailing_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit B1—None	**COA RAE-3** • New member packet_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM230 Member Disability Rights Request_RAE • See language on web, "for our members": www.coaccess.com	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit B1—None	**COA RAE-3** • PNS218 Physician Incentive Plans_RAE	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: COA staff members reported that the RAE has no physician incentive plans that meet the definition of a physician incentive plan in the RAE contract with the Department; therefore, HSAG scored this requirement *Not Applicable*.		

Results for Standard V—Member Information							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	16
Total Score ÷ Total Applicable						=	94%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. Contract Amendment 1: Exhibit B1—7.3.12.1	**COA RAE-3** • CCS315 EPSDT_RAE • See COA website: https://www.coaccess.com/members/care/epsdt/	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information: • The RAE employs Department materials to inform network providers about the benefits of well-child care and EPSDT. • The RAE ensures that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 1: Exhibit B1—7.6.2.3, 12.8.3.4; 12.9.3.4	**COA RAE-3** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The RAE shall create an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE shall train Healthy Communities contractors about the Accountable Care Collaborative and the RAE's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding	**COA RAE-3** • DHHA Healthy Communities MOU • TCHD Health Communities MOU_RAE	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4		
Findings: COA submitted a Tri-County Health Department (TCHD) memorandum of understanding (MOU) and scope of work (effective December 2018) which documented the commitment of COA and TCHD to work together in a two-year formal planning process to develop and implement an onboarding plan for Medicaid children and families. Staff stated that the organizations are meeting bimonthly to accomplish the planning process. At the time of on-site review, COA had not created an annual onboarding plan in collaboration with Tri-County Healthy Communities contractors. COA continues to refer members and providers to Healthy Communities for assistance in accessing services.		
Required Actions: COA must expedite the planning and implementation process with the Tri-County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.		
4. The RAE assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit B1—12.8.7.6	**COA RAE-3** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE • EPSDT UMCM training report_RAE • EPSDT in Action R3_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280. (EPSDT program). For the Capitated Behavioral Health Benefit, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under.	**COA RAE-3** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE • See COA website: https://www.coaccess.com/members/care/epsdt/	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures provision of all appropriate mental/behavioral health developmental screening to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
6. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social	**COA RAE-3** • CCS315 EPSDT_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61-62* Contract Amendment 1: Exhibit B1—14.5.3		
7. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational.	**COA RAE-3** • CCS315 EPSDT_RAE • EPSDT in Action R3_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not more costly than other equally effective treatment options. Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
8. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities; clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 1: Exhibit B1—14.5.8.1	**COA RAE-3** • CCS315 EPSDT_RAE • EPSDT in Action R3_RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard XI—EPSDT Services							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	88%

Appendix B. Record Review Tools

Based on the sensitive nature of the coordination of care record reviews, they have been omitted from this version of the report. Please contact the Colorado Department of Health Care Policy and Financing's Office of Cost Control & Quality Improvement for more information.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **COA R3**.

Table C-1—HSAG Reviewers and COA R3 and Department Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Katherine Bartilotta	Associate Director
COA R3 Participants	**Title**
Aaron Bove	Care Manager
Aaron Brotherson	Director of Provider Relations
Aleasha Sykes	Care Coordinator, Manager
Amanda Berger	Supervisor of Care Management
Ana Brown-Cohen	Health Program Manager
Andrea Rodriguez	Compliance Contractor
Bethany Himes	Vice President of Provider Engagement
Bryce Anderson	Supervisor of Care Management
Cassidy Smith	Senior Program Director
Chase Gray	Senior Director of Health Services
Danielle Schroeder	Care Management, Manager
Elizabeth Strammiello	Chief Compliance Officer
Eric Bretillo	Director of Marketing and Communication
Gretchen McGinnis	Senior Vice President of Healthcare Systems
Jamie Zayac	Supervisor of Care Management
Janet Milliman	Director of CHP+ and Program Deliverables and Operations
Jason Beard	Web Manager, Strategic Communications
Jenny Nate	Director, Behavioral Health Provider and Network Support
John Wilson	Care Manager
Joseph Anderson	Director of Care Management
Josie Koth	Programs Coordinator
Kelly Marshall	Director of Community and External Relations
Krista Beckwith	Senior Director of Population Health and Quality
Lauren Showers	Care Manager

COA R3 Participants	Title
Lindsay Cowee	Director of Utilization Management and Pharmacy
Marty Janssen	Senior Program Director
Michelle Tomsche	Director of Claims Operations and Research
Mika Gans	Manager of Quality Improvement
Rebecca Fox	Care Manager
Reyna Garcia	Senior Director of Customer Service
Robert Bremer	Vice President of Network Strategy
Shelby Kiernan	Director of Practice Transformation
Stephanie Becker-Aro	Care Manager
Toni Johnson	Care Manager
Department Observers	**Title**
Amanuel Melles	Program Administrator
Chris Tzortzis	Program Administrator
Jeff Appleman	Program Specialist
Ben Harris	Program Specialist
Russ Kennedy	Quality and Compliance Specialist
Gina Robinson	EPSDT Program Administrator

Appendix D. Corrective Action Plan Template for FY 2018–2019

If applicable, the RAE is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the RAE should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the RAE must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the RAE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The RAE must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the RAE is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the RAE to proceed with implementation, or • Instruct the RAE to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the RAE has received Department approval of the CAP, the RAE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The RAE will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the RAE will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the RAE within the intervening time frame.) If the RAE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the RAE's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the RAE's discretion at any time the RAE determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the RAE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for completion established by the Department. HSAG will continue to work with the RAE until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for COA R3

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit B1—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	COA's website included clear and concise information about the elements outlined in the requirement. However, the section that addressed filing and processing appeals contained outdated information.	COA must ensure that information on its website includes updated and correct information regarding appeals procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
3. The RAE shall create an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE shall train Healthy Communities contractors about the Accountable Care Collaborative and the RAE's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	COA submitted a Tri-County Health Department (TCHD) memorandum of understanding (MOU) and scope of work (effective December 2018) which documented the commitment of COA and TCHD to work together in a two-year formal planning process to develop and implement an onboarding plan for Medicaid children and families. Staff stated that the organizations are meeting bimonthly to accomplish the planning process. At the time of on-site review, COA had not created an annual onboarding plan in collaboration with Tri-County Healthy Communities contractors.	COA must expedite the planning and implementation process with the Tri-County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The RAEs also submitted a list of care coordination cases that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the RAE's key staff members to obtain a complete picture of the RAE's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG reviewed a sample of administrative records to evaluate care coordination activities and outcomes. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with RAE staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2018–2019 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the RAE and the Department for review and comment. • HSAG incorporated the RAE's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the RAE and the Department.

Appendix F. Focus Topic Discussion

Overview of FY 2018–2019 Focus Topic Discussion

For the FY 2018–2019 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE*. Focus topic interviews were designed to emphasize the member-related and provider-related components of transition and integration, including successes and challenges experienced in this inaugural year of RAE operations. HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the 2018–2019 RAE Aggregate Report to determine and document statewide trends related to the ACC objective of integrating behavioral and physical healthcare for members. This section of the report contains the interview guide and a summary of the focus topic discussion for **COA R3**.

Members

Transitioning Members Into the RAE and Continuity of Care

Prior to RAE implementation, **COA** was the Regional Care Collaborative Organization (RCCO) for Region 3 and the administrative service organization (ASO) for Behavioral Healthcare, Inc. (BHI), the BHO in the region. By working with the Department and BHI claims database, **COA** was able to use a data-driven methodology to identify Region 3 RCCO members receiving BH services through BHI. BHI and **COA** prepared lists of potentially high-risk members for continuity of care and provided advanced messaging to these members to introduce **COA** as the new organization through which they would receive their BH services. Member letters provided assurances that if the member was receiving services in one of the four Region 3 counties nothing would change. BHI and RCCO care managers met weekly to discuss members in active care coordination and arrange a warm handoff from BHI to **COA** coordinators. For members in authorized placement, the BHI care manager remained involved with the member; and care managers worked together to eventually transition the member to **COA**. In addition, **COA** identified BH providers serving Region 3 members and prioritized those providers for contracting with the RAE.

Prior to RAE implementation, the Department, awarded RAE contractors, BHOs, and many provider and community stakeholders were involved in numerous meetings to discuss implications of transitioning BHO members to the RAE. Discussions focused on anticipating the impact of the Department's new attribution model—assignment to an RAE based on location of the member's assigned PCMP—and designing consistent messaging to members. **COA** explained that attribution issues were "not unanticipated" given that several coinciding processes were in effect at the time of RAE implementation, including a new Department-contracted vendor to perform attribution, revalidation of Medicaid providers by the Department, and the new attribution methodology itself.

COA anticipated some shift in member population between RAE regions, particularly for members residing in the border areas of the Region 3 counties; however, the initial attribution data identified significant shifts in member population, both in and out of the region, and had to be worked through with the Department. Department letters to members, which communicated the member's assigned PCMP, caused much consternation for members. For the first 30 to 90 days following RAE implementation, general inquiries to **COA** customer services increased significantly. **COA** conducted training for its customer service and care management teams concerning the new attribution methodology, designed member messaging scripts, and instructed staff on when and how to escalate concerns to another level of investigation. If members were receiving services from a BH provider not yet contracted with the RAE, **COA** applied continuity-of-care rules so that the member could continue care with a non-contracted provider for a period of time.

COA identified two specialized member populations most impacted upon implementation of the RAE. Children in each county's DHS Division of Child Welfare (foster care) were previously assigned to a region based on the county aligned with that region's boundaries. The new attribution methodology confused the relationship between county DHSs and the RAE concerning medical management and care coordination of these children. **COA** designated internal staff members to work individually with each of the four county DHSs to resolve any issues and to ensure that the core providers for foster care children were contracted with the RAE. Staff members reported that this one-on-one relationship has strengthened **COA**'s relationship with each of its county DHSs. Likewise, geriatric members who are dual-eligible Medicare and Medicaid beneficiaries were sometimes aligned with a Medicare-only provider who did not previously need to be contracted with Medicaid. Members were reassigned through the attribution process to a Medicaid network PCMP, causing initial panic among some geriatric members. **COA** prioritized those members' providers for contracting with the RAE, including application to the State Medicaid network if necessary.

Due to the overlap of the RCCO and previous BHO in Region 3, **COA** reported that most members receiving BH services were transitioned into the RAE without disruption to ongoing care.

Care Coordination

In addition to transitioning high-risk BH members into RAE care coordination as previously described, **COA** increased the number of behavioral health care managers to accommodate integration of BH into the RAE. **COA**'s care coordination program is organized into care coordination specialty teams, including a specialized BH transition-of-care team and a BH ongoing care management team. Transition of care teams are aligned with specific BH facilities to enhance consistency of relationships and communications between facility and **COA** care managers. Upon initiation of the RAE contract, several care managers from BHI were hired by **COA**, furthering the potential for continuity of relationships with members and providers. Internal **COA** specialized care teams collaborate to coordinate care for members with complex needs. Care management documentation systems now incorporate the full spectrum of an individual member's behavioral, physical, and social support needs and an integrated whole-person care plan. For members transitioning between RAEs, members in active treatment for authorized services are coordinated between the RAEs. Staff members stated that member attribution to PCMPs in Region 6 has resulted in transition of many members to BH providers in Jefferson County. **COA** believes that collaboration with other RAEs due to shifting member attribution has improved relationships among care coordinators across the RAEs.

Providers

Transitioning BH Providers Into the RAE and Provider Network Contracting

COA was the previous BHO contractor in Region 5, the previous ASO for Region 3, and the RCCO in both regions. Due to the proximity of the two regions, RAE Regions 3 and 5 have long operated as a single region. At the time of RAE implementation, **COA** had pre-established contracts with a large network of BH providers across both regions—all CMHCs and 5,000 independent provider network (IPN) providers. **COA** was able to transition all existing provider contracts to the RAE rather than re-contracting with BH providers. This highly expedited contracting process allowed **COA** to prioritize its resources to work with Region 3 BH providers regarding the changing dynamics within the provider network due to association with the ACC and with **COA**'s philosophies. To facilitate the transition of BH providers into the RAE, **COA** held large provider training sessions and provider forums to familiarize providers with the new concepts and terminology of the ACC and to work through integration concerns as identified. **COA** noted that solo or part-time IPN providers were particularly isolated and disconnected from the system. **COA** included all BH providers in quarterly RAE provider forums, encouraging networking among providers.

A significant change in the BH provider dynamics associated with **COA** concerned the role of the CMHCs. CMHCs in Region 3 were previously owners in the BHO—BHI—and would have no ownership interest in the RAE. Those CMHCs also had specific catchment areas and established members. Conversely, **COA** has historically placed higher emphasis on IPN providers who are much more involved in the delivery system than they were in BHI. **COA** has focused considerable effort on meeting regularly with CMHC leadership to encourage them to consider themselves part of a fluid system of member access and integrated provider relationships. **COA** has explored mechanisms to positively promote the integration of CMHC and IPN providers in the region while minimizing CMHCs' perceptions that competition exists with IPN providers and/or may threaten the reimbursement levels of the CMHCs. **COA** discussions with CMHC leadership included exploration of payment system innovations. **COA** reported that the provider community as a whole positively views the diverse and integrated BH system of care as an improved model for meeting the needs of the overall population.

The substance abuse disorder (SUD) provider network did not align with the RAEs as these providers were aligned with the managed service organizations (MSOs). **COA** worked with the regional MSO to identify SUD providers and outreached to each residential and inpatient SUD provider to educate on BH network changes within the RAE. **COA** aligned with the Office of Behavioral Services to align messaging to these providers.

At the time of on-site review, **COA** had 49 integrated physical health and behavioral health practices in Region 3. While **COA** is open to facilitating transition of any BH provider interested in working within an integrated PCMP practice, **COA** also has been discussing with CMHCs the possibility of co-locating, offering BH therapists for hire, or providing other supports for PCMP integrated practices. Staff members stated that Mental Health Center of Denver (MHCD)—the CMHC in Region 5—had experience with "match-making" between PCMPs and BH therapists and encouraged Region 3 CMHCs to work with MHCD on strategies. Staff members described **COA**'s enhanced payment model to

support PCMP practices that have employed BH providers, stating that the FFS reimbursement for up to six BH visits is too low to support the financial viability of integrated practices. Twelve PCMP sites are currently participating in the enhanced payment model, and **COA** intends to expand access to enhanced payment methodologies to additional integrated practice sites.

COA also discussed the tele-behavioral health program offered by **COA** to all PCMPs to offer peer-to-peer consultations or virtual therapy to members in primary care offices. **COA** hires BH clinicians to provide these services free of charge to PCMPs. **COA** offers direct member therapy for up to six in-office therapy sessions, as allowed by the RAE's fee-for-service BH code. Not all provider offices are able to hire an in-office BH provider or expand office services to accommodate an on-site BH therapist; therefore, the tele-health services enable more widespread delivery of BH services throughout the RAE network. **COA** currently has 27 PCMPs participating in this service. Peer-to-peer consultation can also be applied to other BH modalities, such as medication management. Staff members stated that medication changes for members have been the most significant outcome of this service. In 2018, **COA** tele-behavioral health clinicians provided 300 direct patient encounters and 498 peer-to-peer consultations. **COA** plans to expand the offering of tele-health services to all BH providers and will involve the CMHCs in expansion strategies. **COA** practice transformation teams and telehealth trainers work with individual practices to help them understand how to integrate various BH modalities into their practices.

Opportunities/Challenges

COA identified additional challenges encountered in transitioning BH services into the RAE:

- While **COA**'s previous contracts with an extensive network of BH providers in both Regions 3 and 5 enabled **COA** to easily transition those contracts to the RAE, this process confused many providers who were required to establish a new contract with other RAEs. In addition, some BH providers desired to renegotiate rates (providers considered **COA** rates comparatively low)—through a new contracting process with **COA**. Provider contracting personnel communicated with all providers to clarify the expedited contracting process and explain that **COA** could not legally discuss rates being paid by other payors.
- BH providers must be contracted with multiple RAEs in order to serve members attributed to PCMPs in various regions. Each RAE has different rules and processes (e.g., authorizations), and member grievance processes are now the responsibility of the RAE (not CMHCs). In addition, BH providers with multiple contracts are required to bill several RAEs for services. The necessity to contract with several RAE regions has resulted in burdensome administrative processes for BH providers previously associated with a single BHO.
- Due to attribution of members to the RAE associated with each assigned PCMP, some members have shifted their BH care to providers in other regions.

COA identified that other general RAE implementation challenges included:

- Many stakeholder organizations whose activities or services are tied to regional boundaries do not align with the RAE or member attribution to the RAE; these include county DHSs, community organizations, county alliances, and SUD providers. To facilitate discussions with these groups, **COA** expanded its governance council membership and, from January through July 2018, dedicated efforts to hosting community meetings as well as meeting with individual organizations to identify concerns and solutions.
- Staff members reiterated that shifts in member populations due to RAE attribution methodology had a profound effect on members, providers, and the RAE. **COA** cited an example as follows: When RAE members called the enrollment broker for assistance or information, many members found that their PCMPs did not appear on the RAE contracted provider list. This issue was due to the fact that a member's description of the name of a clinic did not match the legal description of the name on the provider list or because provider identification numbers needed to be associated with a specific office location aligned with the RAE. **COA** worked with providers and the enrollment broker to correct this problem. However, **COA** stated that significant attribution issues continue and that collaborative efforts among RAEs across the State and with the Department also continue to resolve these issues.

COA articulated several opportunities resulting from integration of BH into the RAEs:

- **COA** has strengthened its provider support teams to initiate strategies to make the provider experience better. Provider support personnel have worked to resolve individual and collective provider concerns "behind the scenes" in order to allow members to transparently transition into the RAE. **COA**'s goal is to make the provider experience the least burdensome possible. Staff members also cited efforts across RAEs and with the Department to standardize and streamline messaging and programming for providers as a positive development. Members interface primarily with their providers; therefore, **COA** believes that more satisfied providers result in a better member experience.
- Networking among care coordinators and program managers across RAE regions has increased sharing of best practices. In addition, criminal justice programs overlap across regions and provide opportunities for increased collaboration.
- Consolidating the customer service experience into one point of contact for the RAE's members receiving physical health or behavioral health services has improved member experience and promoted more consistency in messaging for members.
- The SUD delivery system is difficult for members to navigate, and many new medication-assisted therapy (MAT) providers have entered the market. **COA** foresees great potential for expanding tele-behavioral health services to extend the services of certified addiction counselors into integrated primary care practices. In addition, integrating tele-health services into corrections programs to interface with criminal justice involved (CJI) members could significantly improve care and outcomes for those members.