COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 Site Review Report

for

Colorado Access

Region 3

March 2021

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 Proposal 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers 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 PCCM entities and PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities 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) 2020–2021 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 FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing 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 (CAP) process that the RAE will be required to complete for FY 2020–2021 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) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

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)
VII. Provider Participation and Program Integrity	16	16	16	0	0	0	100%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
X. Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**69**	**69**	**0**	**0**	**0**	**100%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **COA R3** and **COA R5** combined for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	84	84	0	16	100%
Recredentialing	90	77	77	0	13	100%
Totals	**190**	**161**	**161**	**0**	**29**	100%

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

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

Regarding provider participation selection and retention efforts, **COA R3**'s senior provider network contractor reported that mostly providers outreached **COA R3** to join the network, and minimal additional outreach was needed as most providers were already in-network due to **COA R3**'s longstanding work in the Denver-metro area. One notable accomplishment for the year was **COA R3**'s work to renew contracts with some of the larger provider groups in the region. The provider network team continued to seek to fill the gap, similar to other health plans, for eating disorder specialists. Due to the reported "robust" network, single case agreements were reportedly only requested once or twice a week, and more commonly used for placement or out-of-state needs. Efforts to retain quality providers included provider newsletters, support from provider relations, and occasional webinars/calls for idea sharing. Staff members described plans to improve assessment of new providers and monitoring of the existing network in 2021, using the expansion of Colorado's substance use disorder (SUD) benefit to launch this new approach.

The provider network and contracting teams used the systems ACES and Determine, which provided the functionality that **COA R3** needed. ACES was developed internally and Determine was described as an off-the-shelf solution. ACES was used to track follow-ups, pending contracts, what documents were out for signature, and contracts that were in the credentialing phase.

Regarding program integrity, the compliance team used "Passport Provider Trust" to screen employees. This system was implemented toward the end of calendar year (CY) 2019. Staff members reported that lists developed by human resources were sent to the compliance team and run through the system, scanning for any issues related to employees or temporary staff members. Provider checks were run by the configuration department.

Compliance policies and procedures included thorough details about training content, and compliance staff members developed numerous tailored trainings, which were deployed in various departments. Clear and effective lines of communication and expectations for prompt reporting were evident as well as comprehensive information about fraud, waste, and abuse. A vendor, NavEx, operated the compliance hotline, while **COA R3** compliance staff members conducted all investigations.

COA R3 operated a three-tiered Compliance Committee structure, which spanned from management level, the executive team, up to the board of directors for wide-ranging oversight. Agenda topics included audits from the previous quarter; privacy and security activities, including a summary of significant issues; and a review of the health plan's risk profile, which was described as mostly stable (due to the focus being internal to **COA R3**, not provider focused). Reports were generated semi-annually and included summaries of audits, referrals to the State, and recoupments. Additionally, the compliance team described monthly meetings with other departments such as claims, care management, provider relations, utilization management (UM), and finance to discuss trends.

Summary of Findings Resulting in Opportunities for Improvement

COA R3's compliance department demonstrated effective training for general staff members through annual all-staff trainings and reported an additional 20-plus customized trainings. However, **COA R3**'s compliance documents lacked specific training details regarding the compliance team. Documents did not include procedures or expectations for the compliance team above and beyond the annual trainings that general staff members received. HSAG recommends detailing the procedures or arrangements for compliance staff members to receive training and education as needed for their roles.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

COA R3's credentialing and provider data department demonstrated extensive policies and procedures for credentialing and recredentialing providers. These procedures followed National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and demonstrated a uniform approach to assess applications. Documentation demonstrated thorough review criteria, sources for verification, and file management steps to ensure accurate and timely credentialing decisions were made.

The credentialing software system, Apogee, housed all network management information and linked data to the provider directory, which was reported to sync updates every evening. The credentialing team described regular monitoring and quality assurance checks to ensure accuracy of additions, terminations, and delegated provider data. In addition to the credentialing team, a business support team provided oversight and support.

Regular monitoring included Web crawler functionality, which was described as an automated approach for license and board certification verification that automatically downloaded information, which was then cross-verified by staff members. The system included the ability to flag any actions or issues found during the search. Anything not verified by the Web crawl was then checked in the National Practitioner Data Base (NPDB). Staff members reported success in reducing credentialing turnaround times from an average of 44 days down to an average of 22 days.

Overall, **COA R3** described thorough measures for daily review of credentialing and recredentialing efforts for providers who submitted clean applications (referred to by **COA R3** as "L1s") as well as detailed and more extensive reviews of any providers with noted issues (known as an "L3 review"). Small errors in applications were reported to be relatively common; credentialing staff would outreach

the provider to verify any necessary information and ensure updated and/or correct information was included in the final application. L3 review criteria were developed by the **COA R3** Credentialing Committee and included threshold criteria for deeper review of applications; for example, an application with two or more malpractice claims (which demonstrated a pattern), a malpractice claim of more than a specified dollar amount, any cases involving the death of a patient, and any attestation question on the Council for Affordable Quality Healthcare (CAQH) that was marked "yes."

A review of credentialing, recredentialing, and organizational credentialing records demonstrated 100 percent compliance with timely initial and ongoing reviews, which included all key criteria within verification time limits: education; work history; board certification (when applicable); Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification (when applicable) sanctions; licensure; signed applications; malpractice insurance coverage; and history of any disciplinary issues, sanctions, limitations, or restrictions. One provider sample included a flagged action against a provider; Credentialing Committee minutes demonstrated a thorough review of the provider was conducted and a unanimous vote to continue working with the provider was confirmed. Overall, **COA R3** reported that less than a handful of applications were rejected each year. Organizational provider assessments performed by **COA R3** ensured that organizational providers were in good standing and had been reviewed and approved by an accrediting body, or if a provider was not accredited, that a quality review was performed by a CMS or State quality review (i.e., Office of the Inspector General [OIG]).

The Credentialing Committee was comprised of a **COA R3** senior medical director, credentialing staff members, and peer representation such as psychologists, surgeons, physician assistance, and certified nurses to ensure clinical oversight and sound recommendations regarding credentialing and recredentialing decisions.

While **COA R3** documented a procedure in which providers had the opportunity to view their application, correct erroneous information, and receive the status of their application upon request, staff members reported that these requests are quite rare.

Policies and procedures regarding actions taken against a practitioner who did not meet quality standards were broad and general; staff members described in detail the various responsibilities of the credentialing department, credentialing committee, compliance department, and quality department to support appropriate actions, when necessary.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

During the period under review, **COA R3** held delegation agreements for the following services: Cognizant (formerly TriZetto) for claims system services, Navitus for pharmacy benefit management, various entities for provider credentialing, OneTouchPoint for the fulfillment of bulk member letters, and National Medical Review for the review of clinical appeals/specialist clinical review. HSAG reviewed a sample of the delegation agreements, which included language that indicated that **COA R3** maintained ultimate responsibility for complying with State contract terms and conditions and Medicaid managed care regulations. Written agreements outlined the delegated activities, indicated that the contractor agreed to perform the delegated activities, and included provisions for **COA R3** to take action, including revocation, if the contracted entity failed to meet its obligations. Within the delegation agreements, **COA R3** included language that the delegated entity was required to adhere to CMS and State law, retain records for 10 years, and allow for an audit upon the request of **COA R3** or a regulatory body.

The delegation policy noted that **COA R3** would retain ultimate accountability for any delegated CHP+ Medicaid managed care requirements. Within its policy, **COA R3** outlined the procedures for entering into an agreement with a potential delegate. This included the proper vetting of the delegate through both **COA R3**'s legal team and through a pre-delegation audit. During the compliance review, HSAG identified evidence that a potential credentialing delegate had undergone a pre-delegation audit, prior to contracting with **COA R3**. If a potential delegate failed to meet the set standard during a pre-delegation audit, **COA R3** had procedures in place to deny the delegation or to potentially offer the delegate the opportunity to reapply at a later time, at **COA R3**'s discretion.

COA R3 provided policies and procedures related to monitoring its current delegates. Each delegate was reportedly overseen by a business owner that had a direct relationship to the contractor. The credentialing manager audited a sample of records from each credentialing delegate annually. The credentialing manager used a system to calculate a score. Delegates that scored below the standard were required to complete a CAP. The claims team monitored the Cognizant claims activity and reviewed reports submitted by Cognizant monthly. The claims team reconciled activities conducted by Cognizant and discussed discrepancies to ensure a consistent standard was met. The UM team monitored the Navitus pharmacy benefits activity and reviewed reports submitted by Navitus monthly. The UM team also reviewed any member grievances pertaining to pharmacy benefits and the payment error rate to ensure Navitus was held accountable to its agreement.

In the event that a delegate did not meet the standard outlined in the delegation, **COA R3** had policies and procedures to enact CAPs with the delegate. During the review, HSAG identified that **COA R3** had placed a credentialing delegate on a CAP. **COA R3** also had policies and procedures in place to revoke delegation if any of its delegates failed to provide the services outlined in the delegation agreement.

Summary of Findings Resulting in Opportunities for Improvement

HSAG reviewed the delegation agreements submitted by **COA R3** and found that, while the intent of the federally required language appeared in the delegation agreements, some of the language in the agreements did not align directly with the language required in 42 CFR 438.230(c)(2-3). Furthermore, the sample agreements did not include mention of electronic data. In order to more clearly align with the federal requirements, HSAG suggests that **COA R3** consider updating its language to clearly state the delegate's obligation to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and the right of a regulatory body (CMS, etc.) to inspect documentation that is stored electronically.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

HSAG reviewed the annual Quality Assessment and Performance Improvement (QAPI) documents, including the *QAPI Program Description 2020*, the *RAE Region 3 Quality Assessment and Performance Improvement Work Plan*, and the *Annual Quality Report Fiscal Year 19-20*. Oversight of the QAPI program was provided through the Health Strategy Steering Committee.

COA R3's QAPI Program Description and Annual Quality Report described a comprehensive QAPI program that included mechanisms to address care appropriateness, safety, quality, and member experience. Mechanisms to address member over-and underutilization of services included the Client Over-Utilization Program (COUP), identification of utilization trends and efforts to ensure timely UM decisions, and a process that assessed the interrater reliability of decision-makers. Quality and appropriateness of care for members with special healthcare needs was addressed through various care management initiatives and included the identification of treatment barriers and other supports needed to improve health.

COA R3 adopted and disseminated clinical practice guidelines (CPGs) based on reliable evidence; input was solicited through contracted providers. The CPGs were posted to the **COA R3** website on the Provider Forms and Documents page and were accessible to providers as well as members. **COA R3** established a process that assured decisions in operational areas, such as UM, that may be impacted by the CPGs were consistent with updated CPGs.

Grievance data, member survey results, secret shopper calls, and population-based data analyses were used by **COA R3** to evaluate access to care and identify areas of need. **COA R3** also worked with its

subsidiary, AccessCare Services, to expand access through the use of telehealth technology, which provided behavioral health services and provider consultation in primary care settings.

COA R3 implemented two performance improvement projects (PIPs) to improve access and quality of care through a rapid-cycle PIP methodology. The physical health-focused PIP aimed to increase the number of well visits for the sub-population of members ages 10 to 14 years in partnership with a community health center in the region. Initial interventions included telephonic outreach to members who did not have a well visit in the prior year, and education for clinic staff members. The well visit rate initially increased, and then declined, leveling off in February 2020. **COA R3**'s second PIP focused on physical and behavioral health coordination efforts to increase the number of behavioral health follow-up visits after a positive depression screen at a physical health appointment for members ages 10 to 14 years in partnership with a medical group practice in Region 3. Following the initial intervention, the rate increased but was not sustained prior to discontinuation of the PIPs by the Department in March of 2020 due to the coronavirus disease 2019 (COVID-19) pandemic.

COA R3 incorporated the results of its Encounter Data Validation Audit into the FY 2020–2021 QAPI work plan to address low-scoring areas related to service coding accuracy. This plan included participation in an HSAG Quality Improvement Project (QUIP) to improve the accuracy of provider data submissions.

Staff members reported that health information data were collected and managed through multiple systems and configured through **COA R3**'s enterprise data warehouse, which allowed **COA R3** to integrate and submit the necessary data to the Department in the required standardized 837 format. **COA R3** described how claims, encounter, utilization, grievance, appeal, and other data were available for extraction from the data warehouse to complete analyses and reporting, calculate performance, and identify cost and care trends for use across the organization.

COA R3 evaluated the QAPI program through the use of trended performance data to validate the effectiveness of interventions implemented throughout the year. In addition, **COA R3** assessed QAPI program operations annually through the use of a self-assessment tool that was developed in the last year. Findings were reviewed by the Health Strategy Steering Committee to gain input and plan future quality initiatives.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 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 VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's 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.* The Department determined that the review period was January 1, 2020, through December 31, 2020. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials.

HSAG also reviewed a sample of the RAE's administrative records related to both RAE credentialing and RAE recredentialing to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of credentialing and recredentialing. For organizations that were contracted by the Department for administration of two RAE regions, HSAG included five records from each of the RAE Regions for a total of 10 records. Using a random sampling technique, HSAG selected the samples from all RAE credentialing records, and all RAE recredentialing records that occurred between January 1, 2020, and December 31, 2020. For the record review, the RAE received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. HSAG separately calculated a record review score for each record review requirement and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those

outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 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 III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

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.

3. Follow-Up on Prior Year's Corrective Action Plan

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **COA R3** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals. **COA R3** did not have any required actions for access and availability, but related to coverage and authorization of services and grievances and appeals, **COA R3** was required to:

- Ensure that RAE members 1) receive written notification of any decision to deny a service, including denial or partial denial of a claim; 2) that the notice of adverse benefit determination (NABD) is written in a language that is easy for the member to understand; and 3) that the NABD includes all required content.
- Update policies to 1) include accurate time frames, including exceptions, for NABD mailings and 2) ensure members receive written notification of any denial of a service, including partial denials.
- Revise UM and claims payment procedures to clarify post-stabilization procedures.
- Implement a mechanism to ensure grievances that involve clinical issues are sent to individuals with clinical expertise for resolution.
- Ensure that grievance acknowledgement letters are sent within time frames; grievance resolution letters are sent within time frames and easy for the member to read; and, if grievance extension letters are sent, they include the member's right to file a grievance if the member disagrees with the extension.
- Ensure appeal resolution letters are easy for the member to read.
- Revise appeal resolution letters to ensure that only the information pertaining to the member's right to an SFH is included.
- Update policies to accurately depict a member's right to request continuation of benefits and associated timelines during appeals and SFHs.

Summary of Corrective Action/Document Review

COA R3 submitted a proposed CAP in May 2020. HSAG and the Department reviewed and approved portions of the proposed plan and responded to **COA R3**. **COA R3** submitted initial documents as evidence of completion in August and October 2020. **COA R3** resubmitted final CAP documents in November 2020.

Summary of Continued Required Actions

COA R3 successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract Amendment #4: Exhibit B-4—9.1.6	**Both R3 and R5:** • PNS202 Selection and Retention of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* RAE Contract Amendment #4: Exhibit B-4—9.3.4.2.1; 9.3.5	For RAE—applies only to BH providers. **Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.	**Both R3 and R5:** • PNS202 Selection and Retention of Providers • CR301 Provider Credentialing and Recredentialing ○ Procedure #2 • CR305 Assessment of Organizational Providers **R3-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.1-2	**R5-specific:** NA	
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.4	**Both R3 and R5:** • PNS202 Selection and Retention of Providers ○ Procedure #1.F • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract Amendment #4: Exhibit B-4—9.1.13	**Both R3 and R5:** • PNS202 Selection and Retention of Providers ○ Procedure #1.G-H • PNS217 Single Case Agreements Policy • Provider Participation Agreement **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—9.1.15, 17.9.4.2.5, 17.10.5.1-2	**Both R3 and R5:** • CMP206 Sanction and Exclusion Screening • CR DP04 Ongoing Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—17.9.4.2.1-4	**Both R3 and R5:** • CMP206 Sanction and Exclusion Screening • CMP DP08 Compliance Program Operations Manual ○ Conducting Exclusion Screens • CR DP04 Ongoing Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract Amendment #4: Exhibit B-4—14.7.3	**Both R3 and R5:** • CS212 Member Rights & Responsibilities • Provider Agreement ○ Section #H.4 • Provider Manual Section 2 ○ Alternative Treatment Options **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* RAE Contract Amendment #4: Exhibit B-4—7.3.6.1.13-14, 14.4.7	**Both R3 and R5:** • Colorado Access does not object to providing any services under the contract • Provider Manual Section 2 ○ Moral or Religious Objections **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program.	**Both R3 and R5:** • Colorado Access Compliance Plan • CMP204 Compliance Education and Training • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts • CMP213 Internal Compliance Reviews • CM DP08 Compliance Operations Manual • Board of Directors FACC Charter • Code of Conduct • New Hire Training Compliance FWA **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract Amendment #4: Exhibit B-4—17.1.3, 17.1.5.1-7		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6-8)* RAE Contract Amendment 4: Exhibit B-4—17.1.6, 17.1.5.9, 17.7.1, 17.5.1	**Both R3 and R5:** • Colorado Access Compliance Plan • CM DP08 Compliance Operations Manual ○ Overpayments ○ Reporting Suspected Provider or Member Fraud-Suspending Payments • CMP211 Fraud Waste and Abuse • CMP212 False Claims Acts **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes	**Both R3 and R5:** • ADM300 Provider Termination • ADM DP02 Notification to the State-Change in Network Providers Circumstances • CM DP08 Compliance Operations Manual ○ Overpayments ○ Member Services Verification • CS DP25 Change in Member Status	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.7.2-5, 17.1.5.7.1, 17.1.5.7.6, 17.3.1.3.2.1, 17.3.1.1.2.3-4, 17.3.1.3.1.1	**R3-specific:** NA **R5-specific:** NA	
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608(b)* RAE Contract Amendment #4: Exhibit B-4—9.2.1.1, 9.3.2, 17.9.2	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #7 • CR305 Assessment of Organizational Providers ○ Procedure #2 • PNS 202 Selection and Retention of Providers ○ Procedure #1.B • Provider Agreement Template **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract Amendment #4: Exhibit B-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	**Both R3 and R5:** • CMP 206 Sanction Screening • LGL DP02 Disclosure of Change in Ownership and Control • The State automatically adjusts capitation payments **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.8, 17.3.1.2.4.4	**Both R3 and R5:** • CM DP08 Compliance Operations Manual ○ Overpayments • CLM DP10 Provider Identified Claim Overpayments • Provider Manual Sections 2 & 6 ○ Overpayments **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract Amendment #4: Exhibit B-4—14.14.1-2, 17.14.2-4	**Both R3 and R5:** • Provider Agreement o Section #C.6 • CM DP08 Compliance Operations Manual o Investigating and Reporting Member Balance Billing Issues **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RAE Contract Amendment #4: Exhibit B-4- 9.3.4.2.1	Note: These are NCQA MBHO requirements available at the time of drafting this tool (6/2020). **Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *42 CFR 438.214(a)* NCQA CR1—Element A1	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedure #1.A-B, #6 • CR305 Assessment of Organizational Providers o Procedure #1 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #13 • CR305 Assessment of Organizational Providers ○ Procedures #3 & #5 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Both R3 and R5:** **Both:** • CR301 Provider Credentialing and Recredentialing ○ Procedures #7, #9, #13, & #14 • CR305 Assessment of Organizational Providers ○ Procedures #2, #3, & #5 • CR DP04 Ongoing Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedures #6-14 • CR305 Assessment of Organizational Providers ○ Procedures #2-6 • CR DP02 Organizational Assessment File Audit • CR DP04 Ongoing Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	**Both R3 and R5:** • CR301 - Provider Credentialing and Recredentialing ○ Procedure #2 • Committee Confidentiality and Non-Discrimination Statement **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure # 4 • CR DP01 Provider Rights **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #15 • CR305 Assessment of Organizational Providers	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ Procedure #7 **R3-specific:** NA **R5-specific:** NA	
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Both R3 and R5:** • CR301 - Provider Credentialing and Recredentialing ○ Procedures #3 & #8 • CR305 Assessment of Organizational Providers ○ Procedure #6.A **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #6 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #16 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #4 • CR DP01 Provider Rights **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #4 • CR DP01 Provider Rights **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedure #4 • CR DP01 Provider Rights **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing ○ Procedures #2 & #8 • CR305 Assessment of Organizational Providers ○ Procedure #6 • CR DP04 On-going Monitoring of Providers ○ Procedure #3 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedure #8 • CR305 Assessment of Organizational Providers o Procedure #6 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days.) • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days).	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedures #7 & #13 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Both R3 and R5:** • CMP206 Sanction and Exclusion Screening • CR301 Provider Credentialing and Recredentialing o Procedure #13.J • CR305 Assessment of Organizational Providers o Procedure #5.A-B • CR DP04 On-going Monitoring of Providers o Procedure #2	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3-specific: NA **R5-specific:** NA	
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedure #9.B **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedure #11.B • CR305 Assessment of Organizational Providers o Procedure #5.I	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3-specific: NA **R5-specific:** NA	
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedure #10 • QM201 Quality of Care Concern Investigation o Procedure #5.A • CMP206 Sanction and Exclusion Screening • CR DP04 On-going Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.*	**Both R3 and R5:** • CR301 Provider Credentialing and Recredentialing o Procedures #10 &11 • CR305 Assessment of Organizational Providers o Procedure #6 • CR306 Adverse Actions Hearing Policy and Plan for Providers	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR6—Element A	• QM201 Quality of Care Concern Investigation ○ Procedure #5.A • CR DP04 On-going Monitoring of Providers ○ Procedure #3 **R3-specific:** NA **R5-specific:** NA	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	**Both R3 and R5:** • CR305 Assessment of Organizational Providers ○ Procedures #2,#3, #5, & #6 • CR DP04 On-going Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Both R3 and R5:** • CR305 Assessment of Organizational Providers ○ Procedures #2, #3, & # 5 • CR DP04 On-going Monitoring of Providers **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**Both R3 and R5:** • CR305 Assessment of Organizational Providers ○ Procedure #5.H **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Element B	**Both R3 and R5:** • CR305 Assessment of Organizational Providers ○ Procedure #1 **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses behavioral health care providers every 36 months. NCQA MBHO CR7—Element C	**Both R3 and R5:** • CR305 Assessment of Organizational Providers • CR DP02 Organizational Assessment and File Audit **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/re-credentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to	**Both R3 and R5:** • ADM223 Delegation • CR301 Provider Credentialing and Recredentialing ○ Procedure #5 **R3-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	**R5-specific:** NA	
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Both R3 and R5:** • ADM223 Delegation ○ Procedure #1.B **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect.	**Both R3 and R5:** • ADM223 Delegation ○ Procedure #3 • CR301 Provider Credentialing and Recredentialing ○ Procedure #5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	**R3-specific:** NA **R5-specific:** NA	
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Both R3 and R5:** • CR DP15 Delegation Audit Process **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.1	**Both R3 and R5:** • ADM223 Delegation **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements.* *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	**Both R3 and R5:** • ADM223 Delegation **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	**Both R3 and R5:** • ADM223 Delegation **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	**Both R3 and R5:** • ADM223 Delegation **R3-specific:** NA **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.230(c)(3) RAE Contract Amendment #4: Exhibit B-4—4.2.12.6		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* RAE Contract Amendment #4: Exhibit B-4—16.1.1	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program **R3-specific:** **NA** **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one for physical health and one for behavioral health.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—16.3.1, 16.3.5, 16.3.8	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program **R3-specific:** • Annual Quality Report RAE 3 **R5-specific:** • Annual Quality Report RAE 5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract Amendment #4: Exhibit B-4—16.4.1, 16.4.4	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program **R3-specific:** • Annual Quality Report RAE 3 **R5-specific:** • Annual Quality Report RAE 5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract Amendment #4: Exhibit B-4—16.6.1	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program • CCS302 Medical Criteria for Utilization Review • CCS307 Utilization Review Determinations **R3-specific:** • Annual Quality Report RAE 3 **R5-specific:** • Annual Quality Report RAE 5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI program includes mechanisms for identifying, investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. RAE Contract Amendment #4: Exhibit B-4—16.7.1.1, 16.7.2	**Both R3 and R5:** • QM 201 - Quality of Care Concern Investigations **R3-specific:** • Annual Quality Report RAE 3 **R5-specific:** • Annual Quality Report RAE 5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* RAE Contract Amendment #4: Exhibit B-4—16.2.1.4 10 C.C.R. 2505-10, 8.205.9	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program • QM302 - Quality Review of Provider Medical Records **R3-specific:** • Annual Quality Report RAE 3 **R5-specific:** • Annual Quality Report RAE 5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • CAHPS survey • ECHO survey RAE Contract Amendment #4: Exhibit B-4—16.5.1-2, 16.5.6	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program **R3-specific:** • Annual Quality Report RAE 3 **R5-specific:** • Annual Quality Report RAE 5	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract Amendment #4: Exhibit B-4—16.2.5	**Both R3 and R5:** • Quality Assessment and Performance Improvement (QAPI) Program **R3-specific:** **NA** **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate.	RAE contract—practice guidelines apply to BH services. **Both R3 and R5:** • QM311 – Clinical Practice Guidelines **R3-specific:** **NA**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.236(b) RAE Contract Amendment #4: Exhibit B-4—14.8.8.1-3	**R5-specific:** **NA**	
10. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract Amendment #4: Exhibit B-4—14.8.8	**Both R3 and R5:** • QM311 - Clinical Practice Guidelines • Website – https://www.coaccess.com/providers/resources/quality/ **R3-specific:** **NA** **R5-specific:** **NA**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract Amendment #4: None	**Both R3 and R5:** • QM 311 - Clinical practice guidelines • CCS302- Medical Criteria for Utilization Review **R3-specific:** **NA** **R5-specific:** **NA**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract Amendment #4: Exhibit B-4—15.1.1	**Both R3 and R5:** • Systems to Manage Health Information Data • COA Architecture Diagram V1.6 **R3-specific:** **NA** **R5-specific:** **NA**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B—15.1.1, 8.1	Note: For RAEs, these elements apply only to BH services. **Both R3 and R5:** • Systems to Manage Health Information Data • COA Architecture Diagram V1.6 **R3-specific:** **NA** **R5-specific:** **NA**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the	Note: for RAEs, claims/encounter systems relate only to BH capitated services. **Both R3 and R5:** • COA Architecture Diagram V1.6 • Claims SW-01	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.2	**R3-specific:** **NA** **R5-specific:** NA	
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.1, 15.2.2.3.2	**Both R3 and R5:** • Systems to Manage Health Information Data • COA Architecture Diagram V1.6 • Claims SW-01 **R3-specific:** **NA** **R5-specific:** **NA**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts.	**Both R3 and R5:** • Systems to Manage Health Information Data • Mechanisms to Ensure Accurate and Complete Data **R3-specific:** **NA** **R5-specific:** NA	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.1, 15.2.2.3.5.1		
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract Amendment #4: Exhibit B—4-15.2.2.3.2-3, 15.2.2.3.5	**Both R3 and R5:** • Systems to Manage Health Information Data • COA Architecture Diagram V1.6 • Claims SW-01 **R3-specific:** **R5-specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Colorado Access Region 3 and Region 5

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	December 8, 2020–December 10, 2020
Reviewer:	Sarah Lambie
Health Plan Participant:	Travis Roth

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: ***** Credentialing Date: 01/21/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: ***** Credentialing Date: 02/06/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: ***** Credentialing Date: 02/21/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: ***** Credentialing Date: 05/20/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: ***** Credentialing Date: 06/11/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Colorado Access Region 3 and Region 5

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: ***** Credentialing Date: 06/26/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: ***** Credentialing Date: 08/28/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: ***** Credentialing Date: 09/01/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: ***** Credentialing Date: 09/15/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: ***** Credentialing Date: 10/10/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**2**	**10**	**2**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**2**	**10**	**2**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**84**
Total Number of Compliant Elements	**84**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs
9. Application must be complete (see compliance tool for elements of complete application)
10. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Colorado Access Region 3 and Region 5

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	December 8, 2020–December 10, 2020
Reviewer:	Sarah Lambie
Health Plan Participant:	Travis Roth

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: ***** Current Recredentialing Date: 01/23/20 Prior Credentialing or Recredentialing Date: 04/14/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: ***** Current Recredentialing Date: 02/14/20 Prior Credentialing or Recredentialing Date: 04/05/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: ***** Current Recredentialing Date: 05/08/20 Prior Credentialing or Recredentialing Date: 07/19/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: ***** Current Recredentialing Date: 05/19/20 Prior Credentialing or Recredentialing Date: 07/21/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments: Provider received a Letter of Admonition for providing clients with an outdated mandatory disclosure statement. The Committee reviewed the updated disclosure and unanimously agreed to reapprove the provider for three years.									
File #5 Provider ID: ***** Current Recredentialing Date: 06/09/20 Prior Credentialing or Recredentialing Date: 08/25/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: ***** Current Recredentialing Date: 08/14/20 Prior Credentialing or Recredentialing Date: 08/29/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: ***** Current Recredentialing Date: 09/24/20 Prior Credentialing or Recredentialing Date: 11/09/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: ***** Current Recredentialing Date: 10/05/20 Prior Credentialing or Recredentialing Date: 12/19/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: ***** Current Recredentialing Date: 10/10/20 Prior Credentialing or Recredentialing Date: 12/21/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: ***** Current Recredentialing Date: 09/03/20 Prior Credentialing or Recredentialing Date: 10/11/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**10**	**3**	**4**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**3**	**4**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**77**
Total Number of Compliant Elements	**77**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Applicable if the practitioner states on the application that he or she is board certified
4. Malpractice settlements in most recent five years
5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
6. Verified that provider is not excluded from participation in federal programs
7. Application must be complete (see compliance tool for elements of complete application)
8. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **COA R3**.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Sarah Lambie	Project Manager II
Erica Arnold-Miller	Project Manager II
COA R3 Participants	**Title**
Amanda Fitzsimons	Senior Privacy Analyst
Bill Huron	Compliance Program Manager
Cassidy Smith	Senior Program Director
Eileen Barker	Senior Director of Behavioral Health
Elizabeth Strammiello	Chief Compliance Officer
Jason Smith	Senior Provider Network Contractor
Laura Coleman	Senior Quality Improvement Program Manager
Michelle Tomsche	Director of Claims Operations and Research
Mika Gans	Director of Quality Improvement
Stacy Stapp	Quality Improvement Program Manager
Travis Roth	Credentialing Manager
Department Observers	**Title**
Amanuel Melles	ACC Program Administrator
Matthew Jacobs	ACC Program Administrator
Matthew Pfeifer	ACC Program Specialist
Russell Kennedy	Quality and Compliance Program Manager

Appendix D. Corrective Action Plan Template for FY 2020–2021

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 SAFE 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.

HSAG identified no required actions; therefore, the CAP template is not included.

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 the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

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 Department 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, 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 RAEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided RAEs with proposed site review dates, group technical assistance and training, as needed. • HSAG confirmed a primary RAE contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site 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 site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and site review activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and 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 RAE also submitted a list of all provider credentialing records and all provider recredentialing records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). The RAE submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review.

For this step,	HSAG completed the following activities:
	HSAG notified the RAE five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct RAE Site Review**
	• During the site review, HSAG met with groups of the RAE's key staff members to obtain a complete picture of the RAE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the RAE and the Department for review and comment. • HSAG incorporated the RAE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the RAE and the Department.