COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2021–2022 Site Review Report

for

Colorado Access

Region 3

February 2022

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. Additional revisions were released in November 2020, with an effective date of December 2020. 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) 2021–2022 site review activities for **Colorado Access (COA)**. 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2021–2022 and the required template for doing so. Appendix D 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: Sep 27, 2021.

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
V. Member Information	18	18	17	1	0	0	94%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**41**	**41**	**40**	**1**	**0**	**0**	**98%**

*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.

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

COA's care coordination and continuity of care policies and procedures provided a comprehensive overview of the care coordination program for RAE 3 members, including those with complex and high-risk needs. **COA** demonstrated its use of systemwide resources dedicated to addressing member needs.

COA has multi-disciplinary care coordination teams organized by physical health, behavioral health, and resource and referral, tailored to the population such as members in foster care. These teams included mostly professionally licensed staff, such as behavioral health professionals and registered nurses (RNs). When a new member enrolls, the Department conducts a health needs assessment (HNA) and sends the results to **COA**. Care coordinators then followed a procedure for telephone outreach to members whose HNAs indicated additional needs. **COA** determined level of care needs based on the members' responses in the assessment.

The Altruista Health GuidingCare software system housed all key care coordination documentation. At the time of the review, staff members reported that RAE 3 had 6,722 members in care management with almost a 50 percent follow-up success rate connecting with members based on HNA data. Established members in need of care coordination or a referral can reach out to **COA** directly and the resource and referral team will process their requests through a queue in the Altruista Health system. Additionally, **COA** described that referrals come in from numerous sources such as the member, the Department, Denver Human Services, and admission, discharge, and transfer (ADT) data through the Colorado Regional Health Information Organization (CORHIO). Though referrals may come in through different sources, **COA**'s processes and systems ensures all referrals are addressed and assigned through the core team. When care coordinators reach out to the members, staff members described the use of pre-developed scripts or assessments to determine member needs—whether healthcare-related, spiritual, or financial—are considered and respected. **COA** described various registries such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), the Client Overutilization Program (COUP), and Healthy Mom/Healthy Baby, and an outreach list from the Colorado Department of Corrections for lower-level outreach for members in care management. For members in care management, members were informed of their assigned care manager through personal outreach calls.

To identify any barriers for members trying to access their primary care medical provider (PCMP), **COA** monitored an attribution dashboard. The attribution dashboard presented data to allow the practice support team to identify when a member accessed services from a provider that was not their assigned PCMP. Although **COA** did not outreach the member directly to address possible access barriers, **COA** noted that re-attribution was a Department mechanism that addressed appropriately re-assigning the member based on utilization data.

Care coordinators developed service or treatment plans for members with serious health conditions, complex medical issues, or special health care needs (SHCN). For members in these condition groups, care coordination is available for longer time periods, if needed. Staff members reported that care

managers, coordinators, and providers are in frequent communication with the member about plans of service/care, interventions, goals, and discharge planning. Staff members described that member assessments and treatment plans are shared through frequent communication from parties involved in the member's care. **COA** has active staff members and care managers on-site at 19 hospitals in the region and procedures are upheld due to long-standing relationships. Notably, one hospital facility allowed direct access into its record system.

To reduce duplication of services, **COA** described its role in leading coordination between community organizations and human service agencies, and regularly holds operational and interdisciplinary meetings. Throughout the care coordination process, **COA** outlined measures in place to safeguard members' protected health information (PHI). When sharing information with other entities about the member, **COA** described sharing the minimum necessary and only authorized information. Information is exchanged through secure channels (i.e., encrypted emails) and only authorized personnel have access to the Altruista Health software system, according to their roles. **COA** conducted staff trainings about protecting member information and used authorizations to disclose PHI.

Summary of Findings Resulting in Opportunities for Improvement

COA described the procedure for members' notification of their assigned care manager through personal care coordinator outreach calls. Though the outreach calls convey all the general required information, HSAG recommends a follow-up letter detailing the information and resources provided over the phone should the member want to reach out to their care manager.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

The **COA** Member Rights and Responsibilities policy included all rights guaranteed to its members as stated in 42 CFR 438.100. In addition to this policy, **COA** maintains a new member booklet that specifies all rights and responsibilities afforded to its members and promotes that members may exercise and express their rights without fear of retaliation. Furthermore, **COA** provided a weblink in its new member booklet for members to access to learn more about their rights. **COA**'s Member Materials policy outlined how member materials are reviewed by the appropriate department and tested by the member advisory council to uphold communications that are easily understandable.

COA presented a Nondiscrimination policy and procedure that described how staff members address allegations of discrimination and civil rights violations on behalf of members. The policy stated that "Colorado Access does not exclude or deny or limit benefits to, condition the coverage, or otherwise discriminate against, any member on the grounds of health status, development of End Stage Renal Disease (ESRD) after enrollment, race, color, national origin, sex, religion, creed, sexual orientation, mental or physical disability or illness, age, genetic information, claims information, source of payment, evidence of insurability, including conditions arising out of acts of domestic violence, or participation in, or receipt of services and benefits under any Colorado Access program or activity." **COA**'s website and provider manual offered information on diversity and cultural training programs that foster respect and appreciation of differences in perspectives, beliefs, backgrounds, race, and sexual orientation. The training program available to **COA**'s staff members and providers included details to promote culturally sensitive services.

COA's policies, procedures, website, and provider manual included information to inform members and staff on advance directives. The member website provided an overview of advance directives and supplied members with additional State resources. In addition, **COA** staff members stated that they had no objections organization-wide, but if a provider cannot execute or implement an advance medical directive as a matter of conscience, the provider will issue a written or other appropriate form of statement of limitation to the member. During the virtual interview, **COA** staff members described that information about advance directives is communicated through mechanisms such as staff trainings, the provider manual, and the website; this was evidenced in the documents submitted for review.

COA provided an array of documents to demonstrate how the organization protects PHI. In addition to this, staff members stated that **COA** reinforces confidentiality through trainings, which was evidenced in additional documents submitted by **COA**.

Summary of Findings Resulting in Opportunities for Improvement

Within the Member Disability Rights Request and Complaint Resolution policy, COA includes timelines to submit an Americans with Disabilities Act of 1990 (ADA) complaint and receive a resolution. HSAG noted that the timeframes to submit a complaint, resolve a complaint, and submit an appeal if the member did not agree with the outcome of the complaint resolution all follow the Office of Civil Rights timelines. However, HSAG recommends updating this policy to clarify that if a member submits a complaint with COA, that COA must resolve the grievance within the State-required timeframes. Additionally, COA should clarify that staff members may assist the member in submitting a complaint with the Office of Civil Rights and that the timelines and appeal procedures currently listed in the policy coincide with that external process.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

HSAG observed that member materials provided for review were easily understood and compliant with Section 508 guidelines. **COA** provided Member Advisory Council (MAC) meeting minutes that detailed an ongoing review process for such materials. Staff members discussed the accessibility widget tool that enabled **COA** to internally ensure accessibility and readability of member information on its website. The Culturally Sensitive Services for Diverse Populations policy described health literacy techniques that staff members must follow. These techniques include, but are not limited to, testing readability, keeping the message simple, understanding the audience, and presenting all member-facing materials to the MAC to be "member tested" prior to dissemination. **COA** submitted a Member Materials policy that outlined the procedures and standards for ensuring that the information in the member materials is effectively communicated.

The Health First Colorado (HFC) member handbook and new member booklet detailed the services and behavioral health benefits that are offered to members. These documents outlined the basic mental health benefits and emphasized benefits that may require pre-approval. Included in the HFC member handbook is the HFC website and contact information for members to request additional information about benefits. **COA**'s new member booklet, annual member mailing, and information found on the website (including videos) were clear and designed to help members understand the benefits and services available.

To monitor the distribution of the new member booklet and all other supplemental materials provided by **COA** to members, the organization maintains a new member mailing list. One example of monitoring

new member mailings is a file review which tracks the total number of active members, active members since last update, members removed, and members dropped due to "bad" addresses.

COA submitted an *Effective Communication with Limited English Proficiency (LEP) and Sensory Impaired/Speech Impaired (SI-SI) Persons* policy that discussed the availability of language interpretation/translation, including American Sign Language, and/or auxiliary aids and services provided at no cost to the member. The policy stated that materials and communication requested in the prevalent non-English language or alternative format will be noted in the member's record, although staff members reported during the interview that some of these capabilities were still pending implementation into the record system (estimated completion in spring/summer of 2022). **COA** staff members described the provision of materials in other formats when needed, which included Braille and audio formats.

HSAG noted that **COA** had robust processes to ensure that specific documents available electronically on the **COA** website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines. During the interview, staff members responsible for these processes demonstrated the tools used for testing. The provider directory enabled members to search and select providers using different criteria such as the provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty, and whether the provider will accept new enrollees. The provider directory also included the cultural and linguistic capabilities offered by the provider or provider's office and ADA accessibility options at the provider's office.

Summary of Findings Resulting in Opportunities for Improvement

COA's new member booklet stated, "If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803- 4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free." HSAG recommends that **COA** clarify that receiving the information in large print, Braille, other formats, and the translation call are *all* at no cost to members.

Additionally, HSAG recommends that all critical materials include language that informs members of their right to receive documents in paper format within five business days.

Summary of Required Actions

While **COA** has a Provider Terminations policy in place stating that **COA** will send a written notice within 15 days of issuance of the termination notice, the federal language was updated in December 2020 to include, "or 30 days prior to the effective date of the termination." Staff members reported communication efforts to clarify with the Department if **COA** should include the 30-day timeline in the policy. Although the State contract had not been updated to reflect the federal revision at the time of the review, **COA** is required to update the timeline in accordance with federal regulations (42 CFR

§438.100 and 42 CFR 438.10). **COA** must update policies and procedures to include the language, "or 30 days prior to the effective date of the termination."

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

COA submitted detailed early and periodic screening, diagnostic, and treatment (EPSDT) policies, procedures, interactive voice response (IVR) scripts, and samples of outreach letters that demonstrated adherence with a multi-stream outreach approach to engage and inform pregnant members and members ages 20 and under about benefits. **COA**'s vendor, Welltok, conducted IVR calls using a detailed script for initial outreach, prenatal outreach, well-visit reminders, and postnatal care. The IVR system included capabilities to increase its daily call volume in cases where significant membership increases occurred in a month, which ensured timely outreach per the State contract requirements.

Customer service and care management staff members received EPSDT-specific training from the Department and could easily access additional reference tips available through the Knowledge Bank system if a member called in with questions or needs. The customer service training document included steps to transfer a member to care management and how to take accurate and detailed notes. Once transferred to care management, a member of the resource and referral team followed a variety of scripts which included assessing the member's specific physical health, mental health, and other needs such as housing, transportation, food assistance, utility assistance, smoking cessation, or other needs.

COA stated that the only covered services related to EPSDT that required prior-authorization were residential services and in the case of a medical necessity denial, the utilization management team would issue a denial letter which included information for how the member could seek other covered services. Staff members noted that residential placements and respite services were challenges and often associated with wait times for members. In these instances, the care management team described its work to supplement services to help fill care gaps, as appropriate. Staff members reported that the utilization management (UM) department and care management team maintained close contact with the contracting team and provider support team to address provider shortages. The contracting and provider support team worked to stay in contact with providers throughout Colorado and also looked for service availability in other states, if needed.

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 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of 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, 2021, through December 31, 2021. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of 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.

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 D 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 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievance and Appeal Systems, 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.

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 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 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** until it completed each of the required actions from the FY 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed 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. **COA** did not have any findings resulting in required actions.

Summary of Corrective Action/Document Review

COA successfully completed the FY 2020–2021 review, and there were no findings resulting in corrective actions for the standards reviewed.

Summary of Continued Required Actions

COA successfully completed the FY 2020–2021 review, and there were no findings resulting in continued corrective actions for the standards reviewed.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit*, the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 7: Exhibit B6—11.3.1, 11.3.7	**Both R3 and R5:** • CM100 Colorado Access Care Coordination ○ Care Coordination Definition ○ Care Management Definition ○ Policy Section ○ Procedure Section ▪ 2.C.1 ▪ 2.C.4 ▪ 2.C.11 • Coordination and Continuity of Care Overview **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact their designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 7: Exhibit B6—None	**Both R3 and R5:** • New Member Booklet ○ Page 4 (as identified in the booklet) • CM100 Colorado Access Care Coordination ○ Procedure 2.A.3 **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 7: Exhibit B6—6.8.1	Colorado Access has created a reporting tool (dashboard) that identifies members seeing a PCMP other than whom they are attributed. The practice support team uses this tool to engage directly with providers to attempt to identify issues. COA supports member choice and the right to see whatever provider a member chooses; members are not prohibited from seeing a PCMP to whom the member is not attributed. Additionally, the Department has implemented a six month reattribution process that reassigns members based on claims activity. This appears to be the most effective method of ensuring members are attributed to providers with whom they have chosen to seek care. COA is also available to assist members in the event they have issues with a PCMP (the grievance team) or they wish to find a new provider. We also	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	have anecdotal evidence that the pandemic impacted member movement due to pandemic-related staffing issues with medical providers. **Both R3 and R5:** • Attribution Dashboard Screenshot **R3 specific:** **R5 specific:**	
4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extended assistance and include appropriate interventions. Contract Amendment 7: Exhibit B6—11.3.3	**Both R3 and R5:** • CM100 Colorado Access Care Coordination ○ Care Management Definition ○ Policy Section ▪ Policy Statement ▪ Section D ○ Procedure Section ▪ 2.B.3 ▪ 2.C.4-5 **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 7: Exhibit B6—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 14.3	**Both R3 and R5:** • CM100 Colorado Access Care Coordination ○ Policy Section ▪ Policy Statement ▪ Section K ○ Procedure Section ▪ 2.C.4-5 • CM101 Delivery Continuity and Transition of Care for Members **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit	**Both R3 and R5:** • CM100 Colorado Access Care Coordination ○ Procedure Section ▪ 1.D ▪ 2.B.1	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 7: Exhibit B6—7.5.2–3	• CM DP11 Health Needs Assessment Call Back Program ○ Section 1 **R3 specific:** **R5 specific:**	
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems *42 CFR 438.208(c)(2-3)* Contract Amendment 7: Exhibit B6—14.7.1	**Both R3 and R5:** • CM100 Colorado Access Care Coordination ○ Procedure Section 2.C.2-4 **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 7: Exhibit B6—None	**Both R3 and R5:** • CM100 Colorado Access Care Coordination ○ Procedure Section 2.C.3 **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* Contract Amendment 7: Exhibit B6—11.3.7.10.6, 15.1.1.5	**Both R3 and R5:** • PRI 100 Protecting Member PHI • PRI 101 Clinical Staff Use and Disclosure of Member PHI • PRI 103 Authorizations to Disclose Member PHI • PRI 104 Member Rights and Requests Regarding PHI • PRI 105 Personal Representatives and Member PHI • PRI 200 Sanctions Policy • HIP 204 Security of EPHI • COA Provider Manual Section 3 ○ Page 3-3 Patient Record Documentation • COA Provider Manual Section 4	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ Page 4-1 Primary Care Providers (PCPS) bullets 10-11 ○ Page 4-3 Specialty Care Providers bullets 6-7 **R3 specific:** **R5 specific:**	
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history,	**Both R3 and R5:** • Guiding Care Screenshots **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
medications, social supports, community resources, and member goals. Contract Amendment 7: Exhibit B6—15.2.1.1, 15.2.1.3-4		

Results for Standard III—Coordination and Continuity of Care—RAE 3							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 7: Exhibit B6—7.3.7.1–2	**Both R3 and R5:** • CS212 Member Rights and Responsibilities **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 7: Exhibit B6—17.10.7.2	**Both R3 and R5:** • ADM205 Nondiscrimination ○ Policy Statement • ADM230 Member Disability Rights Request and Complaint Resolution ○ Policy Statement • CS212 Member Rights and Responsibilities ○ Policy Statement second paragraph • Provider Manual Section 2 ○ Page 2-2 Nondiscrimination ○ Page 2-6 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/ ○ https://www.coaccess.com/nondiscrimination/	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3 specific: **R5 specific:**	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for their dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 7: Exhibit B6—7.3.7.2.1–6	**Both R3 and R5:** • CS212 Member Rights and Responsibilities ○ Policy Statement bulleted list • ADM208 Member Materials • Provider Manual Section 2 ○ Page 2-6 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/ **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 7: Exhibit B6—7.3.7.2.7	**Both R3 and R5:** • ADM203 Member Grievances ○ Grievance Definition ○ Procedures Section 1 • Provider Manual Section 2 ○ Page 2-6 Member Rights and Responsibilities • COA Website ○ https://www.coaccess.com/members/services/rights/ • New Member Booklet ○ Page 11 (as identified in the booklet) **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 7: Exhibit B—11.3.7.10.6, 15.1.1.5	**Both R3 and R5:** • PRI100 Protecting Member PHI • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI • PRI104 Member Rights and Requests Regarding PHI • PRI105 Personal Representatives and Member PHI	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• PRI200 Sanctions Policy • PRI204 Security of EPHI • See COA Website ○ http://www.coaccess.com/documents/Notice-of-Privacy-Practices.pdf **R3 specific:** **R5 specific:**	
6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection.	**Both R3 and R5:** • ADM331 Advance Directives ○ Policy statement ▪ 2nd paragraph ▪ 4th paragraph beginning with "Colorado Access will provide members" • PRI105 Personal Representatives and Member PHI • Provider Manual ○ Section 2 ▪ Advance Directives pages 2-7 to 2-8 • COA Website: ○ https://www.coaccess.com/members/services/	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate of staff concerning its policies and procedures on advance directives.	▪ Advance Directives **R3 specific:** **R5 specific:**	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 7: Exhibit B6—7.3.11.2, 7.3.11.3.3		

Results for Standard IV—Member Rights, Protections, and Confidentiality—RAE 3							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit B6—7.2.5, 7.3.6.1	**Both R3 and R5:** • ADM206 Culturally Sensitive Services for Diverse Populations ○ Procedure 2.A-B • ADM207 Effective Communication with LEP and SI-SI Persons ○ Definitions-Plain Language • ADM208 Member Materials ○ Procedure 3 • MKT DP03 Accessibility Standards - 508/ADA Compliance • MAC Minutes **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 7: Exhibit B6—7.38.1	**Both R3 and R5:** • See COA website content and link to ○ HCPF Member Handbook: https://www.coaccess.com/members/care/ • New Member Booklet **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit B6—3.6, 7.3.4	**Both R3 and R5:** • PD Ops DP03 Monitoring Terminology in Contracts **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.	**Both R3 and R5:** • ADM206 Culturally Sensitive Services for Diverse Populations ○ Procedure 2 A-B • ADM207 Effective Communication with LEP and SI-SI ○ Policy Section	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3	• ADM208 Member Materials ○ Definitions-Tagline ○ Policy 1-3 ○ Procedure 3 • MKT201 Printed Marketing/Informational and Corporate Branding Material ○ Procedure 2 A-D **R3 specific:** **R5 specific:**	
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible.	**Both R3 and R5:** • MKT203 Website Design Maintenance and Oversight • MKT DP03 Accessibility Standards 508/ADA Compliance • COA Website: https://www.coaccess.com/ ○ Accessibility Widget in lower left corner of screen	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	○ See "For our Members" on the homepage **R3 specific:** **R5 specific:**	
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(i)* Contract Amendment 7: Exhibit B6—None	**Both R3 and R5:** ○ See COA website for link (https://www.coaccess.com/members/care/) section on Physical Health: ▪ Prescription Drug Benefit Information **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 7: Exhibit B6—7.2.6.2–4	**Both R3 and R5:** • ADM207 Effective Communication with LEP and SI-SI Persons ○ Policy Section • ADM208 Member Materials • CS DP28 Nextalk for TTY_TTD • CS DP29 Interpreting Services • COA Website: ○ https://www.coaccess.com/members/services/ **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 7: Exhibit B6—7.2.6.1, 7.2.6.5	**Both R3 and R5:** • ADM207 Effective Communication with LEP and SI-SI Persons • CS DP29 Interpreting Services • Provider Manual ○ Section 2, page 2-1 Effective Communication and Language Assistance • See COA website and language options at top of page: ○ www.coaccess.com	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R3 specific: **R5 specific:**	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* Contract Amendment 7: Exhibit B6—7.3.8.1	**Both R3 and R5:** • New Member Booklet • New Member Mailing BRD **R3 specific:** **R5 specific:** *Instructions: Unless the RAE has its own handbook or supplement, score this Not Applicable.*	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 7: Exhibit B6—7.3.8.2	**Both R3 and R5:** • ADM328 Significant Changes in Members Rights, Benefits or Processes **R3 specific:** **R5 specific:** *Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable.*	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 7: Exhibit B6—7.3.8.1	**Both R3 and R5:** • ADM208 Member Materials • New Member Booklet ○ Page 1 (as identified in the booklet) **R3 specific:** **R5 specific:** *Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable. If the RAE produces its own handbook or supplemental handbook—(a) review for accuracy of any applicable elements and (b) must reference the Department's handbook.*	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. 42 CFR 438.10(f)(1) Contract Amendment 7: Exhibit B6—7.3.10.1	**Both R3 and R5:** • ADM300 Provider Terminations **R3 specific:** **R5 specific:**	**R3** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While COA has a Provider Terminations policy in place stating that COA will send a written notice within 15 days of issuance of the termination notice, the federal language was updated in December 2020 to include, "or 30 days prior to the effective date of the termination."		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Staff members reported communication efforts to clarify with the Department if COA should include the 30-day timeline in the policy. Although the State contract had not been updated to reflect the federal revision at the time of the review, COA is required to update the timeline in accordance with federal regulations (42 CFR §438.100 and 42 CFR §438.10).		
Required Actions: COA must update policies and procedures to include the language, "or 30 days prior to the effective date of the termination."		
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • The RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory. • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 7: Exhibit B6—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	**Both R3 and R5:** • RAE Website_Std. 5 Requirement 13 **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty	**Both R3 and R5:** • See COA Provider Directory at: o https://secure.healthx.com/s/COA_Provider_DIrectory	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit B6—7.3.9.1.6-7	**R3 specific:** **R5 specific:**	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit B6—7.3.9.1.8	**Both R3 and R5:** • See COA Provider Directory at: ○ https://secure.healthx.com/s/COA_Provider_DIrectory **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The RAE's single toll-free customer service phone number. • The RAE's email address. • The RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections.	**Both R3 and R5:** • New Member Booklet o Page 1 (as identified in the booklet) o Page 2 (as identified in the booklet) o Page 4 (as identified in the booklet) o Page 5 (as identified in the booklet) o Page 12 (as identified in the booklet) • COA Website o https://www.coaccess.com/members/ o https://www.coaccess.com/members/services/apply/ **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 7: Exhibit B6—7.3.6.1		
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 7: Exhibit B6—None	**Both R3 and R5:** • New Member Booklet • ADM207 Effective Communication with LEP and SI-SI Persons • ADM230 Member Disability Rights Request • See language on web, "For Our Members": ○ www.coaccess.com **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 7: Exhibit B6—None	**Both R3 and R5:** • PNS218 Physician Incentive Plans **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information—RAE 3							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	94%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the American Association of Pediatrics "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation. Contract Amendment 7: Exhibit B6—7.3.12.1, 7.6.2	**Both R3 and R5:** • EPSDT FY21-22 Strategic Plan (We have include each region's report but the citations are the same in each one) o C. Methods of Contact Used Page3 • See COA Website o https://www.coaccess.com/members/care/epsdt/ **R3 specific:** • R3_EPSDT_FY21-22 Strategic Plan o C. Methods of Contact Used Page3 **R5 specific:** • R5_EPSDT_FY21-22 Strategic Plan o C. Methods of Contact Used Page3	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 7: Exhibit B6—7.6.3.2	**Both R3 and R5:** • EPSDT FY21-22 Strategic Plan (citations are the same in each report) o C. Methods of Contact Used Page3 • Newly Enrolled EPSDT Letter • COA_Well Visit Minor IVR Script • COA EPSDT Dental Reminder Flyer **R3 specific:** • R3_EPSDT_FY21-22 Strategic Plan o C. Methods of Contact Used Page3 **R5 specific:** • R5_EPSDT_FY21-22 Strategic Plan o C. Methods of Contact Used Page3	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months.	**Both R3 and R5:** • UM104 EPSDT o Procedures Section 1 • Provider Manual Section 10 o Pages 10-4, 10-5, 10-6 **R3 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 7: Exhibit B6—7.6.2.3, 12.8.3.4; 12.9.3.4	**R5 specific:**	
4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). For the *Capitated Behavioral Health Benefit*, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure.	**Both R3 and R5:** • UM104 EPSDT ○ Policy Statement ○ Procedure 1 • Provider Manual Section 10 ○ Pages 10-4, 10-5, 10-6 • See COA website: https://www.coaccess.com/members/care/epsdt/ **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 441.55; 441.56(c) Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
5. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.4.C	**Both R3 and R5:** • UM104 EPSDT ○ Section 3.A 2-6 **R3 specific:** **R5 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. *For the Capitated Behavioral Health Benefit,* the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or	**Both R3 and R5:** • UM104 EPSDT ○ Medical Necessity Definition **R3 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	**R5 specific:**	
7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive	**Both R3 and R5:** • UM104 EPSDT ○ Policy Statement **R3 specific:**	**R3** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 7: Exhibit B6—14.5.7.1, 2.1.1	**R5 specific:**	

Results for Standard XI—EPSDT Services—RAE 3							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	100%

Appendix B. Site Review Participants

Table B-1 lists the participants in the FY 2021–2022 site review of **COA**.

Table B-1—HSAG Reviewers and COA and Department Participants

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Sara Dixon	Project Manager II
Eva Ogbon	Project Manager I
Lauren Gomez	Project Manager I
COA Participants	**Title**
Amanda Fitzsimons	Compliance Program Manager, Colorado Access
Ana Brown-Cohen	Director of Health Programs, Colorado Access
Cassidy Smith	Senior Program Director, Program Deliverable Operations, Colorado Access
Elizabeth Strammiello	Chief Compliance Officer, Colorado Access
Eric Brettillo	Director of Marketing and Communications, Colorado Access
Jamie Zajac	Manager of Care Management, Colorado Access
Jason Beard	Web Manager, Colorado Access
Joseph Anderson	Director of Care Management, Colorado Access
Kate Myers	Health Program Specialist, Colorado Access
Lindsay Cowee	Director of Utilization Management, Colorado Access
Lisa Hug	Senior Manager of Programs, Program Deliverable Operations, RAE 3 Contract Manager, Colorado Access
Marsha Aliaga-Dickens	Manager of Care Management, Colorado Access
Reyna Garcia	Senior Director of Customer Service, Colorado Access
Department Observers	**Title**
Gina Robinson	Program Administrator
Jeff Helm	Program Design and Policy
Russell Kennedy	Quality and Compliance Specialist

Appendix C. Corrective Action Plan Template for FY 2021–2022

If applicable, the health plan 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 health plan 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 health plan must submit documents based on the approved timeline.

Table C-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan 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 health plan 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 health plan to proceed with implementation, or • Instruct the health plan 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 health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan 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 health plan 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 health plan within the intervening time frame.) If the health plan 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 health plan'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 health plan's discretion at any time the health plan 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 health plan 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 health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table C-2—FY 2021–2022 Corrective Action Plan for COA RAE 3

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit B6—7.3.10.1	While COA has a Provider Terminations policy in place stating that COA will send a written notice within 15 days of issuance of the termination notice, the federal language was updated in December 2020 to include, "or 30 days prior to the effective date of the termination." Staff members reported communication efforts to clarify with the Department if COA should include the 30-day timeline in the policy. Although the State contract had not been updated to reflect the federal revision at the time of the review, COA is required to update the timeline in accordance with federal regulations (42 CFR §438.100 and 42 CFR §438.10).	COA must update policies and procedures to include the language, "or 30 days prior to the effective date of the termination."
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix D. 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 D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the 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 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 review dates, group technical assistance and training, as needed. • HSAG confirmed a primary RAE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and review activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the 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 HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the 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 review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and 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.