COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Site Review Report

for

Health Colorado, Inc.

Region 4

June 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

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

Summary of Compliance Results

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

Table 1-1 presents the scores for **HCI** 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	11	11	9	2	0	0	82%
IV. Member Rights and Protections	7	7	7	0	0	0	100%
V. Member Information	19	14	14	0	0	5	100%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	7	1	0	0	88%
Totals	**45**	**40**	**37**	**3**	**0**	**5**	**93%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

HCI provided care coordination (CC) activities for all members in Region 4 through seven delegated entities—Accountable Care Coordination Entities—which included Valley-Wide Health Systems, Health Solutions, San Luis Valley Behavioral Health Group, Solvista Health, Southeast Health Group, High Plains Community Health Center, and San Luis Valley Regional Medical Center. **HCI**'s *Care Coordination Plan* described an overview of **HCI**'s comprehensive care coordination program, principals, processes, and overall organization. **HCI**'s Care Coordination policy described processes for member care coordination and addressed all care coordination requirements of the RAE contract. The *Primary Care Medical Provider (PCMP) Agreement*, executed with each accountable CC entity, designated the PCMP as the primary care case manager and delegated to the accountable CC entity responsibility for the full list of care coordination requirements outlined in **HCI**'s Care Coordination policy. The delegated accountable CC entities also provided care coordination for members attributed to those PCMPs unable to fulfill the comprehensive CC requirements for members with complex needs. In addition, Beacon Health Options' (Beacon) Intensive Care Management team provided support to delegated care coordinators and members with highly intense needs. **HCI**'s *Population Health Plan* and staff members described **HCI**'s stratification methodology to identify members with high-risk, high-cost, or complex care coordination needs.

While the Department's enrollment broker assigned each member to a designated PCMP, **HCI**'s engagement center—i.e., call center—also aligned requesting members with a behavioral health (BH) provider and/or assisted members in changing their designated PCMP. Call center staff informed members of the contact information for those providers. **HCI** published a single point of contact phone number for care coordination, and individual CCs informed a member directly of his or her CC contact number. **HCI** reviewed the Department's attribution list regularly and forwarded information to accountable CC entities; care coordinators followed up with members who appeared to be attributed to an incorrect PCMP. Staff stated that reattribution to a correct PCMP was dependent on the member's motivation to independently contact the enrollment broker to request changing his or her PCMP, due to the enrollment broker prohibiting care coordinator participation in a three-way call with the member and enrollment broker.

Care coordination activities included assisting members with transitions of care between settings—including discharge planning from higher levels of care—and coordinating services with other RAEs, FFS providers, and community social support organizations. Care coordinators reported having an individual contact person at each RAE for conducting a warm hand-off and transition of records for members transitioning in and out of the RAE. Care coordinators also have a referral tracking system for FFS physical health referrals and conduct follow-up with providers and members. Accountable CC entities enabled seamless care coordination of PH and BH services through a variety of mechanisms, including: embedding care coordinators in PCMP locations with integrated or co-located BH providers to participate in members' collaborative health teams; providing external BH providers with direct access to the PCMP's electronic health record (EHR), including the care coordination record; or

conducting a warm hand-off and maintaining communication with other BH providers involved in the member's care. **HCI** documented that BH providers are required to perform an intake assessment and develop a related plan of care with specifically defined documentation components. **HCI** audits BH records to assess compliance with documentation requirements. **HCI** had also developed a comprehensive care coordination audit tool for assessing each delegated care coordination entity's compliance with delegated care coordination requirements. At the time of on-site review, the audit tool had been applied in one accountable CC entity and **HCI** was preparing to expand to all other delegates.

Care coordinators performed member needs assessments on all members and developed individual care plans according to each member's needs and goals. **HCI** policies, delegation agreements, and audit tools all addressed interventions for medical, behavioral, and non-medical needs. Care plans include deliberate provider interventions available to the broader population—e.g., provision of medical and social support referrals, educational resources, and maintaining telephonic and electronic communications. More complex care coordinator interventions include face-to-face visits with members, arranging for and maintaining communications with diverse clinical providers—e.g., substance use providers, hospitals, pharmacists, dentists—and arranging services with transportation providers, numerous State and regional agencies, community resource organizations, and other ancillary service providers. All care plan activities are recorded in the delegate's EHR system. Care coordinators share assessments with other participants in the member's care, including BH providers; through the EHR; or, for external providers without access to the EHR, through verbal communications or via forwarding applicable sections of the comprehensive assessment according to an organization's need to know. **HCI** received results from the Department's health needs survey (HNS), Colorado overutilization program (COUP), and nurse advice line and forwarded the information to the appropriate delegated CC entity to inform member outreach and care coordination activities. While care coordinators performed a comprehensive assessment of member needs within a short time after enrollment, care coordinators stated that Department sources of information could be used to trigger a more timely response to a member-defined need; however, staff reported that only 60 HNSs had been received since inception of the RAE contract.

HCI demonstrated the Connect 4 Care care coordination system used by **HCI** to collect and communicate *some* of the required components of the care coordination tool to the delegated accountable CC entities; however, each accountable CC entity maintained its own electronic care coordination system which included the full care coordination tool for each member. HSAG reviewed the components of the electronic care coordination system for one of the accountable CC entities and found the care coordination tool compliant with the required elements. **HCI** maintained numerous policies and related documents that required providers and care coordinators to maintain confidentiality of member information in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and 42 CFR Part 2 drug and alcohol privacy regulations.

Summary of Findings Resulting in Opportunities for Improvement

HCI's Care Coordination Plan provides an overview of comprehensive care coordination services for RAE members and refers globally to services available for members through a variety of sources and processes; however, due to the high-level description, HSAG needed to clarify on-site the designation of staff and responsibilities within the region in order to clearly comprehend the organization of multiple care coordination processes. HSAG suggests that **HCI** consider enhancing its Care Coordination Plan to include more detailed description of its regionwide model for care coordination—e.g., a more definitive description of its delegated organizational model, alignment with PCMPs, configuration of CC teams, embedded care coordinators, care coordination record integration into EHRs, and access to care coordination information.

HCI's Transitions of Care policy described transition of care services for RAE members and could have been applicable to all RAE members. However, the policy statement reads, "It is the policy of the COS_EC [Colorado Springs Engagement Center] to assist members in transitioning from one system of care to another with minimal disruption in their *behavioral* health services," implying that the policy related to BH members only. As transitions of care requirements are applicable to all RAE members and care coordinators described engaging in transitions of care for all members, HSAG recommends that **HCI** amend its policy to ensure that transitions of care procedures apply to all RAE members and types of health services.

Summary of Required Actions

Each accountable CC entity operates an independent electronic care coordination documentation system; however, the PCMP Full Accountable Agreement did not detail the elements required to be included in the delegate's electronic care coordination tool. Staff members stated that **HCI** performs a pre-delegation assessment of each entity to ensure that each delegate's care coordination tool includes the required elements. While the pre-delegation assessment tool included, "How do you document care coordination? Please provide policy or tool," the assessment did not reflect **HCI**'s review of each delegate's care coordination tool to verify inclusion of the minimum required elements. **HCI** must implement mechanisms to ensure that the electronic care coordination tool used by each accountable CC entity includes the minimum required elements outlined in the RAE contact.

HCI demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining member health records in compliance with detailed documentation standards and for maintaining confidentiality and security of member health records. In addition, care compacts between individual referring and specialist providers—totaling 97 signed compacts at the time of on-site review—required sharing of clinical information between those specific providers. However, no other **HCI** documents clearly communicated expectations that all providers share member records with other providers or organizations involved with a specific member's care. **HCI** must enhance provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

As the administrative services organization for **HCI**, Beacon maintains the policies and procedures related to member rights and protections. The Beacon Member Rights and Responsibilities policy clearly articulated the intent to protect the rights afforded members under 42 CFR 438.100. In addition, Beacon maintained policies to address member rights under other applicable laws and regulations—e.g., anti-discrimination, advance directives, and privacy and confidentiality guaranteed under HIPAA. The policy that addressed development of member communication materials described processes to ensure that materials are easily understood and readily accessible. HIPAA policies addressed access to protected health information (PHI), use, disclosure, minimum necessary requirements, authorization, consent, electronic storage, paper storage, disposal, and handling suspected breaches.

HCI had numerous processes designed to ensure that members and providers are aware of members' rights and that both members and providers are aware that neither providers nor the RAE are permitted to retaliate in any way against members who exercise those rights. Methods to train about and communicate member rights to staff, members, and providers included in-person and webinar trainings, town hall meetings, Member Experience Advisory Council (MEAC) meetings, and provision of information easily accessible and easily understood on the **HCI** website.

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 V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

HSAG found that **HCI** had processes for testing member materials for sixth grade readability and to ensure that specific documents available electronically on **HCI**'s website are machine-readable and comply with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. **HCI** provided evidence that materials and the website had been tested both for 508 compliance and sixth grade readability. All member materials reviewed by HSAG were written in 12-point font with taglines in English and Spanish and in 18-point font. In addition, **HCI** provided evidence that member materials and the content on the website had been member-tested.

HCI had a variety of mechanisms designed to assist members in understanding the benefits and services available. Member Services staff members attended drop-in centers and MEAC meetings with presentations well-designed for members' easy understanding. **HCI** also used a texting campaign to send welcome messages and care reminders. **HCI** provided evidence of effective processes for providing language line assistance for translation and in-person translations (including American Sign Language) when needed. RAE staff members described provision of materials in other formats when needed. **HCI**'s website included all required information through direct description of the information required or through links within the website to pages containing more in-depth description.

The RAE's provider directory included most required provider-specific information. **HCI** has a mechanism to gather information from providers about cultural competency and accommodations for members with physical disabilities; and, when able to obtain the information from providers, **HCI** ensures that it is added to the provider directory.

Summary of Findings Resulting in Opportunities for Improvement

Access to Care standards were present on **HCI**'s website; however, the reader must access the provider tab, then click "Clinical Tools" to find the access standards. While this information is not required to be located in a particular place on the website, **HCI** may want to consider adding a link on the member tab so that this information may be more easily accessed.

Members and providers were informed of the availability of language interpretation (including American Sign Language) through member handouts, MEAC and drop-in center meetings, and the Health First Colorado (HFC) member handbook; providers were informed through the town hall trainings and the provider handbook. The provider handbook, however, states, "The regional organizational requires providers to offer interpreter services for members who are deaf, speak a language other than English, or have other communication disabilities…." While assistance through **HCI**'s Office of Member and Family Affairs is offered, this statement may be misinterpreted by providers to mean that the cost responsibility is that of the provider. On-site, **HCI** staff members confirmed that all language-line and in-person interpreter services are invoiced through the RAE. **HCI**

may want to consider clarifying language regarding interpreter services in the provider handbook so as not to deter providers from making any necessary arrangements.

HCI's website was easy to navigate, and the information provided for members was easy to understand. The website included all content required by the RAE's contract with the State. However, the website information for members, related to quality indicators, was not comprehensive. Under the "Member" tab, HSAG reviewers found information about national studies and **HCI** member surveys regarding improved outcomes associated with peer support specialist programs. **HCI** may also want to consider adding additional quality outcome indicators identified through conducting its overall quality improvement program. HSAG suggests that additional information be presented in a way that members can easily understand.

Summary of Required Actions

HSAG identified no required actions related to this standard.

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

Summary of Strengths and Findings as Evidence of Compliance

HCI's EPSDT policy and procedure comprehensively addressed provision of EPSDT services for members ages 20 and under and outlined **HCI**'s requirements for BH providers to ensure that members receive well-child screening services through the PCMP and that BH providers perform BH diagnostic and treatment services for EPSDT-eligible members referred by a PCMP. The RAE provider handbook included extensive information on EPSDT benefits and services, informed of assistance available through Healthy Communities, and referred providers to HFC to obtain additional information. **HCI** included EPSDT information in provider trainings. The provider handbook and provider documentation trainings included requirements for BH providers to document EPSDT screening results in the member medical record. **HCI**'s clinical record audit tool included review of medical records for documentation of EPSDT-related services and requirements for members ages 20 and under. **HCI** informed members of EPSDT benefits through the **HCI** website.

Both the EPSDT and utilization management (UM) policies and procedures outlined the complete and accurate listing of EPSDT medical necessity criteria, and staff members stated that medical reviewers are familiar with the application of the expanded criteria for approving capitated EPSDT behavioral health benefits. UM staff arranged for provision of vocational services, clubhouse and drop-in centers, intensive case management, residential care, respite services, and other capitated or waiver BH benefits as needed. **HCI** provided documentation to demonstrate that such services are available in the region, primarily through the community mental health centers (CMHCs). UM staff members also assisted providers with authorization requests for services not covered under the capitated benefits but covered by FFS. **HCI**'s intensive care management team, PCMP care coordination teams, provider relations

personnel, and call center staff all assisted members and providers with overcoming barriers to accessing EPSDT-related benefits including transportation, referrals to Healthy Communities, and initiating referrals to HFC's Creative Solutions coordinator when necessary. **HCI** care coordinators have established informal alliances with State and county agencies and community organizations in local areas of the region with which they collaborate to enable referrals for individual members and to maintain familiarity with services available to members within communities. At the time of on-site review, **HCI** was engaged in active discussions with Healthy Communities contractors throughout the region to complete the process of developing an onboarding plan for Medicaid members and families.

HCI demonstrated overall attentiveness to the provision of EPSDT benefits and services for members through the collective efforts of providers, care coordinators, support staff, and local agencies and organizations.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that the EPSDT policy and procedures tended to be oriented toward BH provider expectations and processes. Similarly, provider communications and trainings related to EPSDT were more detailed for BH providers than for PCMPs. While some RAE EPSDT requirements relate only to the provision of the capitated behavioral health benefits—e.g., screening services provided and UM procedures—HSAG recommends that **HCI** review its EPSDT policy and related provider communications to ensure that EPSDT physical health services are also adequately addressed, when applicable.

HCI's primary mechanism for informing members of EPSDT benefits and services was through the **HCI** website; however, **HCI** did not demonstrate having widespread mechanisms for alerting members to refer to the website to obtain information on EPSDT services. HSAG encourages **HCI** to enhance member communications, perhaps through periodic newsletters or other messaging, to inform members of EPSDT-related services and/or to refer members to EPSDT information on the **HCI** website.

The RAE provider handbook included a comprehensive description of EPSDT services and benefits to be provided to members by primary care and BH providers, including frequency of well-child checkups by PCMPs and well-defined expectations of BH providers to work with PCMPs to ensure that EPSDT screenings and appropriate referrals for treatment are received by members. The handbook referred providers to HFC to obtain more information. **HCI** also provided a town hall webinar for providers and a presentation for BH providers, both of which described at a high level EPSDT benefits and requirements and referred providers to HFC to obtain more information. However, HSAG found the following deficiencies in trainings and related materials intended to inform providers of EPSDT services for members: while the provider handbook included the most comprehensive description of EPSDT benefits, **HCI** did not have provider communications to direct providers to the provider handbook for EPSDT information; training presentations for providers included only high-level EPSDT information and were minimally attended by providers; and the provider training tab on the **HCI** website included no information on EPSDT services and requirements. During on-site interviews, staff members stated that **HCI** was planning to improve provider EPSDT trainings by offering monthly webinars which would include an EPSDT-focused training once every six months and by maintaining webinar content on the

website for providers who could not personally attend a webinar. Nevertheless, HSAG found at the time of on-site review that **HCI** had provided minimal EPSDT training, particularly for PCMPs. HSAG recommends that **HCI** strengthen the content of provider trainings to thoroughly educate providers on EPSDT benefits, services, and requirements; and ensure that trainings or updates are available to all providers every six months. In addition, HSAG recommends that provider communications refer providers to the EPSDT information in the RAE provider handbook.

HCI staff members verbally described several resources for assisting providers and members with resolving problems related to EPSDT benefits. Resources included PCMP care coordinators, **HCI**'s Intensive Care Management team, provider relations staff, call center staff, and HFC Creative Solutions staff. However, these resources and processes were not outlined in EPSDT-related documents or provider communications. HSAG recommends that **HCI** consider more definitively outlining in EPSDT procedures and provider communications the various resources for assisting providers and members with accessing EPSDT benefits.

At the time of on-site review, **HCI** was actively engaged with Healthy Communities (HC) contractors to define detailed procedures for collaboratively onboarding children and families. Individual HC contractors have unique resources and operational processes; therefore, HSAG recommended that the proposed agreement detail the processes and procedures related to the unique relationship between **HCI** and each HC contractor.

Summary of Required Actions

Although **HCI** was actively engaged in discussions with four of the five HC contractors in the region and had developed a template memorandum of understanding (MOU) and business associate agreement (BAA) which were anticipated to be signed with each HC contractor by the end of April 2019, at the time of on-site review **HCI** had not executed or implemented an onboarding plan with each HC contractor in the region. **HCI** must complete the process of developing and executing an onboarding plan with each Healthy Communities contractor in the region.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

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

Compliance Monitoring Site Review Methodology

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

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

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

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

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

Objective of the Site Review

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

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

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit*, the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities.	**Documents Submitted/Location Within Documents:** 1. 262L_CareCoordination_2RAE-entire policy 2. CareCoordinationPlan_2RAE-entire policy 3. QM 33F_RAE_CulturalCompetency_2RAE-entire policy 4. Care CoordinationInternalAuditTool-2RAE-entire document 5. ProviderHandbook_2RAE-page 29; 33-35*misc. 6. PCMPFullAccountableAgreement_2RAE-pages 19-23*misc. 7. PopHealthManagementPlan_HCI-entire doc **Description of Process:** The RAE implements procedures to deliver care to and coordinate services for all members, and demonstrates this in the following documents: PopHealthManagementPlan_HCI: The population health plan supports care coordination at the place of care and/or from an existing trusted and local provider, as a critical intervention that is available to all Members in R4. Care Coordination is an intervention that connects our Members and engages them in the resources available is a key intervention to managing our population's health overall. Members are stratified based upon both physical health and behavioral health diagnosis and utilization criteria. Diagnostic Cost Groupers (DCG) provided by Truven and the number of chronic conditions measures the physical health risk. Mental Health Diagnosis, Substance Use Diagnosis (SUD), number of inpatient admissions, emergency room visits and SMI designation are the criteria used to determine behavioral health risk. In addition to the prescribed four quadrants, we have broken out the quadrants into six physical health and six behavioral health categories. The additional	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit B1—11.3.1, 11.3.7	categories will allow for more specific evaluation and ability to identify members moving along the stratification continuum. We used the DCG Range values provided by Truven and split the moderate risk score out into two categories, "Low Moderate" and "High Moderate" we also did the same for the behavioral health continuum. Within the received Truven data, we will also be utilizing the provided ED Visit Risk score to identify members who are at risk for changing stratification. Members who qualify for the Client Over Utilization Program (COUP), will be placed in the Low Moderate category to start, however this may be increased based upon the number of admissions and/or ED visits they have. 262L_CareCoordination_2RAE adheres to this requirement and identifies the Accountable Care Coordination Entity is responsible for coordinating all aspects of the Members care, including the medical treatment team, specialty care and any other health providers involved in the Member's care. Care coordination provided at the point of care whenever possible, is culturally responsive and provided for both short and long-term healthcare needs. Member preferences are respected and regular communication between care coordinators and the practitioners delivering services to Members provided. This policy addresses all components of this requirement, including that it: • 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.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• 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. CareCoordinationPlan_2RAE addresses this requirement specifically and the entire plan is applicable. This plan provides an overview of comprehensive care coordination services for members of the Regional Accountable Entity (RAE). This plan is intended to provide guidance about the scope of care coordination activities, yet it must be acknowledged that the service needs for individual members can vary widely and the specific processes for care coordination may vary, depending upon the type of treatment setting and the staff that are assigned care coordination responsibilities. Members may receive care coordination services through the RAE, or through its partners/providers. Service settings may include individual primary care practices, group medical practices, specialty care settings, behavioral health care settings, including community mental health centers, Federally Qualified Health Centers, and other locations. The RAE works to provide education, monitoring, reporting, training, and communication.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	QM33F CulturalCompetency_Policy_2RAE entire policy underscores the commitment to developing and implementing policies and procedures that will enhance cultural competency; to breaking down barriers to access and utilization that are faced by many minorities when seeking behavioral health care. These barriers include relevancy of services and financial, language, transportation and literacy barriers; to broadening multi-cultural participation in our provider network; to promoting the ethic of cultural competence and educating our staff, providers, partners, Members and the community about Member's rights to culturally competent services. **The Provider Handbook**: Cultural Competency Section page 29 identifies that the regional organization requires all physical, behavioral health and care coordination services are provided in a culturally competent manner. This includes sensitivity to the member's particular language needs and their cultural beliefs and values. **Care Coordination Section** pgs. 33-35 identifies expectations for providers as it relates to Care Coordination, regional strategy, the care coordination delegation model, provider role as it relates to care coordination and care coordination principles. PCMPFullAccountableAgreement_2RAE-pages 19-23 identifies requirements of the Care Coordination Delegated Entities. We work to improve care coordinators knowledge through ongoing trainings/meetings regarding contract requirements. Additionally, providers will be monitored on compliance with this requirement through existing audit procedures. See Care CoordinationInternalAuditTool-2RAE	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit B1--None	**Documents Submitted:** 1. 262L_CareCoordination_2RAE-entire policy 2. CareCoordinationPlan_2RAE-page 5 3. ClinicalAuditTool_2RAE-Section E 4. Care CoordinationInternalAuditTool-2RAE-Section B 5. WelcomMemberLetter_HCI-entire document 6. ProviderHandbook_2RAE-page 26; 33-35 & 71-72 *misc 7. 210L-Routine Member Requests_2RAE-entire policy 8. WellPass_2RAE-entire document 9. WellpassHealthPlanCampaignTemplate_2RAE-entire document **Description of Process:** *We initiate this process internally by providing each of the care coordination entities in Regions 2 & 4 with a list of designated Members attributed to them. The member's "MemberID" (Medicaid ID) is bumped up to the 834 member eligibility dataset to confirm that the member is eligible within the RAE. Once complete, a set of queries assigns a Care Coordinator to the members based off of PCP location. The reports are then sent out to the Care Coordinators via secure email or through FileConnect. We also provide care coordination information to Members on the Website & have a designated CC phone number.* 262L_CareCoordination_2RAE addresses this requirement specifically. The entire policy is applicable. It identifies that the Accountable Care Coordination Entity is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. The care coordinator will share the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste and abuse. CareCoordinationPlan_2RAE-page 5 speaks to Care Coordination being delegate to specific staff person with appropriate knowledge/training to function as the single point of contact with the different systems and settings related to the Member. The Provider Handbook-page 26 encourages *participating behavioral health providers* to communicate with *members* to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by Beacon or a designee of Beacon; page 33-35 identifies the participating provider role in care coordination. Providers are monitored on compliance with this requirement through existing audit procedures. See ClinicalAuditTool_2RAE—Section E. Care Coordination Delegated Entities are monitored on compliance with this requirement through existing audit procedures. See Care CoordinationInternalAuditTool-2RAE-Section B. Members are sent a *Welcome Letter* from their Attributed Provider/Delegated Care Coordination entity. Please see WelcomMemberLetter_HCI	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Beacon Health Options care management team also conducts coordination of care activities in the following situations (See Provider Manual, Page 71-72): Members and participating behavioral health providers may access the Beacon care management system through any of the following avenues: ☐ 24-hour toll-free emergency care/clinical referral line ☐ Direct registration/certification of care through ProviderConnect for participating providers ☐ Direct registration of care through the Interactive Voice Response (IVR) system (in those local Beacon Engagement Centers where IVR is used) ☐ Direct authorization/certification of all levels of care through referral by a Beacon CCM ☐ Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms, or crisis response teams If a call is received from a member requesting a referral and/or information about participating behavioral health providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating behavioral health providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating behavioral health providers holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location, and phone number of at least three	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	participating behavioral health providers will be given to the member. The provider manual also captures CCM review process to determine that the appropriate LOC is being provided. 210L-Routine Member Requests_2RAE entire policy. All member requests are handled expeditiously. Each member attempting to access care directly or by a representative through any Beacon Health Options 24 hour Clinical Referral/Direct line is assessed for risk of self-harm, harm to others, or harm by others and referred to the appropriate level of care. The Members is given information related to Network Providers/Care Coordination Entities including providers' names, addresses and phone numbers in attempt to link with services. Wellpass_2RAE document outlines the secure, HIPAA-compliant messaging platform that sends text alerts/campaigns to Members, including a "welcome to the RAE" onboarding text, outlining resources including access to care coordination with instructions on how to contact the RAE and/or care coordinator. The Wellpass platform supports text messaging, secure inbox messages, email and automated calls, and allows health plans to enroll members in evidence-based health, wellness and condition-specific messaging programs; Create custom messaging programs to meet specific plan goals; Message an entire population (broadcast) or communicate with individual members (person-to-person). WellpassHealthPlanCampaignTemplate_2RAE outlines text bank examples: • Did you know that Health First Colorado pays for most mental health and substance use treatment? For a referral call	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	1-888-502-4185 or visit www.healthcoloradoRAE.com (region 4: https://www.healthcolorado.com)	
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 1: Exhibit B1—6.8.1	**Documents Submitted/Location Within Documents:** 1. AttributionClaimsDataValidationProcess_2RAE-entire doc 2. PR-101A_PCMPProviderContracts_2RAE-entire doc 3. PR-101B_PCMPProviderContracts_2RAE-entire doc **Description of Process:** The RAE compares the Department's attribution and assignment list with Member claims activities to ensure accurate attribution/assignment. The RAE also completes follow-up with Members to identify barriers accessing PCMP's within the region and assist with changing the attributed PCMP when appropriate. This is demonstrated in the following processes: AttributionClaimsDataValidationProcess_2RAE: the entire document outlines the standard operating procedure to verify the attribution list provided by the Department of Health Care Policy and Finance (HCPF) is aligned with claims activity to ensure Members are being assigned to providers in which they have an active relationship with. This process is intended to ensure that this alignment exists in the attribution files provided by HCPF. *Once this process is complete, we provide the list of outliers to the care coordination entities for follow-up to assess for any barriers, as well as to assist with contacting the enrollment broker for reattribution.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PR-101A_PCMPProviderContracts_2RAE entire policy focuses on establishing the process for data entry and maintenance of Primary Care Providers (PCP) in multiple systems to ensure accuracy for Provider Directory, Network Adequacy and other client/regulatory needs. This SOP is for new PCP executed contracts to add contract and all supporting documentation for the Connects Systems and PCP Database. PR-101B_PCMPProviderContracts_2RAE entire policy focuses on establishing the process for data entry and maintenance of Primary Care Providers (PCP) in multiple systems to ensure accuracy for Provider Directory, Network Adequacy and other client/regulatory needs. This SOP is for making any changes, updates or deletions of information for contracted Primary Care Providers. Provider Relations Department ensures all contracted PCMPs by Billing ID are affiliated with the RAE, make any additions, changes or deletes on monthly basis as appropriate. This includes closing or opening panels for new members or geo attribution. Works with internal data analysts to confirm the correct PCMPs by Billing ID when KMR conducts a crosscheck of the attribution and assignment to identify any peculiar attribution (i.e. a non-contracted PCMP has attributed members). Works with PCMP's if they report issues with attribution and forward to HCPF for panel analysis and resolution. This can include PCMP reporting members with claims history not being attributed to them.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit B1—11.3.3.2	**Documents Submitted/Location Within Documents:** 1. 262L_CareCoordination _2RAE-Pages 2-3 2. CareCoordinationPlan_2RAE-Pages 4-5 3. Care CoordinationInternalAuditTool_2RAE-Sections A&B **Description of Process:** The RAE ensures care coordination that includes deliberate interventions for short-term care coordination needs as well as extended interventions that encompass ongoing or long-term care coordination needs by a designated care coordinator. 262L_CareCoordination_2RAE -pages 2-3 reflects expectations that the Care Coordinator will coordinate services and share relevant treatment information identified groups or parties, as appropriate to ensure collaboration of care. Care coordination will be accessible to all Members. Care coordination is comprised of deliberate interventions as well as extended care coordination. Deliberate interventions are available to the broader population and include tactics such as medical and social referrals, telephonic/electronic communications, educational resources, etc. Extended care coordination is targeted to specific member groups who require more intense and prolonged assistance and includes interventions such as care planning, face-to-face visits, etc. CareCoordinationPlan_2RAE outlines that Care Coordinators shall maintain relationships with community organizations such as specialty care, managed service organizations and their networks of substance use providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Resources for Colorado, and other ancillary providers. Develop and maintain comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations. Care Coordination will delegate to specific staff person to function as the single point of contact with the different systems and settings related to the Member. A designated staff person is identified and will have the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population. CareCoordinationInternalAuditTool-2RAE –Sections A&B addresses both short and long-term health needs. Ensures care coordination documentation for developing and maintaining comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including: medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations. Care Coordination documentation for linking members to both medical and non-medical, community-based services, such as child care, food assistance, elder support services, housing, utilities assistance, and other non-medical supports. Shows proof of delegating care coordination duties to designated staff persons to function as the single point of contact	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with the different systems and settings related to the Member; Designating staff persons have the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population; Are providing specific guidance to care coordinators about each setting, regarding how to identify Members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and Member concerns.	
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.	**Documents Submitted/Location Within Documents:** 1. 282L_TransitionsofCare_ 2RAE-entire policy 2. CareCoordinationPlan_2RAE-Pages 2, 4 3. Care CoordinationInternalAuditTool_2RAE-Sections A, B, D and P10-P14 **Description of Process:** The RAE administers the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the Work outlined in the Contract thereby creating a seamless experience for Members and Providers, evidenced by: 282L_TransitionsofCare_2RAE addresses this requirement specifically. The entire policy is applicable as the focus centers on assisting Members in transition, from one system of care to another with minimal disruption in their behavioral health services. The current behavioral health system of care in Colorado is complex and sometimes fragmented by varying payment streams, eligibility requirements, and benefits. Members may need	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(2) Contract Amendment 1: Exhibit B1—14.3, 11.3.10, 11.3.5, 10.3.2, 10.3.4	assistance in navigating this complex landscape to achieve optimal health outcomes. CareCoordinationPlan_2RAE outlines that Care Coordinators shall assist to members who are transitioning between health care settings and populations served by multiple systems, including, but not limited to, children involved with child welfare, Health First Colorado-eligible individuals transitioning out of the criminal justice system, Members receiving LTSS services, and Members transitioning out of institutional settings. ***This policy also outlines that Care Coordination will be accessible to all Members.*** CareCoordinationInternalAuditTool_2RAE –Sections A, B, D and P10-P14 address this standard. Beacon Health Options will be auditing the Care Coordination Entity to ensure coordinated transitions of care in the following situations: transitions of Members from one RAE to another RAE when Members are actively engaged in Care Coordination and/or receiving covered services through the Capitated Behavioral Health Benefit; transitions of Members from institutional settings to community-based services; transitions of Members from in-patient hospital stays to the community; Medicaid-eligible Members transitioning out of the criminal justice system and children involved with Child Welfare. This audit tool also outlines the expectation of maintaining relationships with community organizations such as specialty care, managed service organizations and their networks of substance use disorder providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Resources for Colorado, and other ancillary providers. As well as developing and maintaining comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including: medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations to ***ensure coordination of care/transitions of care for all Members.***	
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 from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit B1—7.5.2–3	**Documents Submitted/Location Within Documents:** 1. EDI_HealthNeedsSurvey_2RAE-entire doc 2. 262L_CareCoordination_ 2RAE-Page 4 3. CareCoordinationPlan_2RAE-Page 6 4. PCMPFullAccountableAgreement_2RAE-page 23*misc. 5. Care CoordinationInternalAuditTool_2RAE-Section P16 **Description of Process:** 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 to retrieve the HNS results for distribution to attributed care coordination entities. This drives member outreach and care coordination activities. EDI_HealthNeedsSurvey_2RAE: **Process**-The FUBS Application runs on an automated schedule to download the Health Needs Surveys. FUBS will look for any new HNS that are made available on the SFTP site. Once FUBS finds a new file, the file is downloaded to a file repository on the server. The file is then	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	processed to the Colorado data warehouse under the [RAE2].[dbo].[HealthNeedsSurvey] database structure. All Health Needs Surveys are appended to this database. **Reviewing Heath Needs Survey Data Set** The member's "MemberID" (Medicaid ID) in the HNS is bumped up to the 834 member eligibility dataset to confirm that the member is eligible within the RAE. The HNS does not have the member demographics such as phone and address. This information is pulled from the 834 member eligibility dataset and is appended to the HNS database. Once the member's demographics have been included in the HNS dataset, a set of queries assign a Care Coordinator to the members based off of PCP location. The reports are then sent out to the Care Coordinators via secure email or through FileConnect. 262L_CareCoordination_2RAE -page 4, CareCoordinationPlan_2RAE-page 6 and PCMPFullAccountableAgreement_2RAE-page 23 all reinforce expectations for the Care Coordination entity to use the results of the Health Needs Survey, COUP and Nurse Advice Line, provided by the Department, to inform Member outreach and Care Coordination activities. Care CoordinationInternalAuditTool-2RAE-Section P16 identifies in the audit tool where this requirement is being assessed/monitored.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit B1—14.7.1.1-2	**Documents Submitted/Location Within Documents:** 1. ProviderHandbook_2RAE-page 68*misc. 2. QM 16B_RAE_Provider Treatment Record Review_Analysis_Reporting_COS_ EC_2RAE-entire policy 3. QM 319.04_2RAE-entire policy 4. ClinicalAuditTool_2RAE-Sections B,C 5. 223L_Treatment Planning_2RAE-entire policy 6. DocumentationTraining_2RAE-entire doc 7. SignInSheet_DocumentationTraining_2019Jan09_2RAE-entire document **Description of Process:** Based on the Member's needs and level of care required, the RAE ensures procedures for the following: each Member receives an individual intake and assessment appropriate for the level of care needed, and a service planning system that uses the information gathered in the Member's intake and assessment to build a service plan. ProviderHandbook_2RAE-page 68: **Behavioral health providers/participating behavioral health providers** must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. CCMs review the treatment plans with the behavioral health providers/participating behavioral health providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum: ☐ Specific measurable goals and objectives	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	☐ Reflect the use of relevant therapies ☐ Show appropriate involvement of pertinent community agencies ☐ Demonstrate discharge planning from the time of admission ☐ Reflect active involvement of the member and significant others as appropriate Behavioral health providers/participating behavioral health providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate. QM 319.04_2RAE: the entire policy covers expectations for Providers related to assessment/treatment planning. Record Reviews are conducted to ensure providers are following best practices in treatment plan development that reflects the Members individual treatment needs. The review is focused on adherence to clinical practice guidelines, use of appropriate measurement based tools, compliance with medical necessity criteria, expedient and flexible treatment planning based on on-going assessments, and discharge planning that begins upon initial assessment and/or admission to a service. Beacon prioritizes treatment record reviews based on contractual obligations and regulatory requirements. QM16B_ProviderTreatmentRecordReviewAnalysisReportingCOSEC_2RAE: entire policy covers review of behavioral health practitioner treatment records to evaluate compliance with the treatment record documentation standards and to monitor adherence to clinical practice guidelines adopted by COS_EC, as	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	part of continuous quality improvement and/or monitoring activity. All COS_EC providers are required to maintain records in compliance with COS_EC, and the State of Colorado standards, which require that "member treatment records are maintained in a manner and includes current, comprehensive, detailed, organized, and legible writing and/or electronic organization to promote effective member-care and quality record review process". Treatment records are subject to audit/reviews by the State of Colorado, COS_EC's Clinical and/or Quality Management/Compliance Departments and accrediting bodies. Provider participation is an integral part of COS_EC's quality improvement program and is a condition of network participation. Policy 223L_Treatment Planning_2RAE-entire policy identifies that that our providers are required to develop treatment plans that are based on data from an individualized assessment and our chart review process will evaluate compliance with this requirement. Providers are monitored on compliance with this requirement through existing audit procedures see ClinicalAuditTool_2RAE-Sections B and C-the auditing focus as it relates to intake assessment and treatment planning requirements and are provided training outlined in the document: DocumentationTraining_2RAE.	

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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 1: Exhibit B1—None	**Documents Submitted/Location Within Documents:** 1. CareCoordinationPlan_2RAE-Pages 2,4,6 2. 262L_CareCoordination_ 2RAE-Page 2 3. Care CoordinationInternalAuditTool_2RAE-Sections B, D, Procedures and P15 4. Compact_Criteria Tool_2RAE-entire doc 5. SAMPLE1_CareCompact_MOU_2RAE-entire doc 6. SAMPLE2_BH CareCompacts_2RAE-entire doc 7. Vaughn Jackson_1care compact_HCI-entire doc 8. South East_highPlains_BallantyneVison_12-20-18_HCI **Description of Process:** The RAE has established and strengthened relationships among Network Providers and the Health Neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts. The CareCoordinationPlan_2RAE captures that care coordinators will reach out and connect with other service providers. The goal is to communicate information appropriately, consistently, and without delay. The ASO will ensure that all care coordination, including interventions provided by Network Providers and Subcontractors meet the needs of the Member. Beacon will provide additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	262L_CareCoordination_2RAE -page 2 addresses this requirement specifically. It identifies that the Accountable Care Coordination Entity is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. The care coordinator will share the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste and abuse. Compact_Criteria Tool_2RAE entire doc-contains Practice information for all practices entering the agreement, initiated or reviewed in the last 12 months and identifies clear expectations **for both primary / specialty care practices**. SAMPLE1_CareCompact_MOU_2RAE entire doc outlines The purpose of this MEMORANDUM OF UNDERSTANDING (MOU)/Care Compact (CC) is to establish a mutual agreement for cooperatively providing medical services as maybe necessary for the health care of patients between specialist and PCP. The MOU outlines mutual interest and benefit to work cooperatively in the provision of services and structures how each will work to establish and define the processes and procedures in the provision of services between the parties. SAMPLE2_BH CareCompacts_2RAE entire doc outlines The purpose of this MEMORANDUM OF UNDERSTANDING (MOU)/Care Compact (CC) specifically related to behavioral	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health. This MOU outlines mutual interest and benefit to work cooperatively in the provision of services and structures how each will work to establish and define the processes and procedures in the provision of services between the parties. It serves as a care compact for establishing clear guidelines for the referral, treatment and effective co-management of patients who are receiving or would benefit from receiving care through both agencies. Both parties agree to work collaboratively for coordination of care for any patients shared in this relationship. Vaughn Jackson_1care compact_HCI---example of specialty care/care compact. SouthEast_highPlains_BallantyneVison_12-20-18care compact_HCI-example of specialty care/care compact. Providers are monitored on compliance with this requirement through existing audit procedures see Care CoordinationInternalAuditTool-2RAE- Sections B, D, Procedures and P15	
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. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	**Documents Submitted/Location Within Documents:** 1. Q4.04_Provider Performance Monitoring_2RAE-entire policy 2. Q2.04_RolesResponsibilityQualityImprovCommittee_2RAE-entire policy 3. QM 16A_ProviderTreatmentRecord_AttachmentA_2RAE-entire document 4. QM 16B_ProviderTreatmentRecord_AttachmentB_2RAE-entire document 5. 33.4_UsesandDisclosure of PHI_2RAE-entire policy*Misc.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	6. Providerhandbook-2RAE-pages 18-19*Misc. 7. HIPAAPrivacy_HCI, page 1 *Misc. 8. HIPAASecurity_HCI, entire document *Misc. 9. HIPAA_HCI, entire document *Misc. 10. Beacon Health Options Practitioner Participation Agreement_2_RAE-page 3 sections 1.9, 9.6 and 9.7 **Description of Process:** As the administrator of a capitated benefit, the RAE employs strategic health care management practices in administering the benefit and creates financial incentives to drive quality care and strong Member experience protections. Q4.04_Provider Performance Monitoring_2RAE entire policy outlines expectations related to maintaining health records in accordance to professional standards. Q2.04_RolesResponsibilityQualityImprovCommittee_2RAE entire policy. This policy monitors compliance, as applicable, with organizational requirements, accrediting organizations, the State of Colorado, and other regulatory agency requirements. QM 16A_ProviderTreatmentRecord_2RAE: This document highlights the Treatment Record Documentation Audit, Treatment Record Review Methodology/ Engagement Center's selection methods for programs/facilities as well as Guidelines for Provider Follow-Up.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	QM 16B_ProviderTreatmentRecord_2RAE: Attachment B offers Guidelines for Treatment Record Compliance Audit Follow-up Actions. 33.5_UsesandDisclosure of PHI_2RAE and Providerhandbook-2RAE addresses the requirements of providers to protect the confidentiality, privacy, and security of identifiable health information. HCI follows the following policies: HIPAAPrivacy_HCI states on page one (1) that HCI will ensure the privacy of an individual's health and personal information as requirement by federal and state regulations. HIPAASecurity_HCI outlines how Health Colorado will protect Members PHI; HIPAA_HCI outlines that HCI will designate a Privacy Office to ensure Member's privacy. Beacon Health Options Practitioner Participation Agreement_2_RAE details the agreement that is entered into between Beacon Health Options and contracted providers. Section 1.9 defines HIPAA and sections 9.6 and 9.7 informs providers that that they will agree to maintain and share member records in a HIPAA compliant manner	
Findings: HCI demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining a member health record in compliance with detailed documentation standards and for maintaining confidentiality and security of member health records. In addition, care compacts between individual referring and specialist providers—totaling 97 signed compacts at the time of on-site		

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
review—required sharing of clinical information between specific providers. However, no other HCI documents clearly communicated expectations that all providers share member records with other providers or organizations involved with a member's care.		
Required Actions: HCI must enhance provider communications regarding the requirement that each provider furnishing services to the member shares, as appropriate, the member health record with other providers or organizations involved in the member's care.		
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, medications, social supports, community resources, and member goals.	**Documents Submitted/Location Within Documents:** 1. Connect4Care_Screenshots_2RAE-entire document **Description of Process:** The RAE possesses and maintains an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. Connect 4 Care is Beacon's Care Coordination tool – Connect 4 Care collects the following data sets to support communication and coordination among members of the provider network and health neighborhood. -834 Member Eligibility data -CORHIO ADT data -Nurse Advice Line data -Health Needs Survey data -Daily Census -COUP data Connect 4 Care aggregates the data sets above to create one "Member Summary Report" (MSR). The MSR will always display the member's Medicaid ID, Age, Gender, Race/ethnicity, PCP assignment and lead Care Coordinator.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 1: Exhibit B1—15.2.1.1, 15.2.1.3, 15.2.1.4	Under the MSR section of Connect 4 Care, 4 other sections will be populated with information only if a member has been reported within these data sets. -CORHIO ADT data -Nurse Advice Line data -Health Needs Survey data -Daily Census -COUP data -Population Health Report - Member stratification Connect 4 Care collection care coordination notes, activities and member needs through the "Update Patient Status" option. The Care Coordinator also has the option to set an alert on the patient under the following categories – **Eligibility and Member Services -** Update Contact Information Contact / Contact Attempt PCMP Change Unattributed with PCMP Selection Special Attention Dismissed from PCMP **Care Delivery -** Scheduled Appointment Rescheduled Appointment Showed for Appointment Referral to Community Service Labwork Ordered Change in medication prescribed Referral to Specialist	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Cancelled Appointment with no reschedule No Show for Appointment Referral to ER Crisis Intervention (Behavioral) Called for ambulance to transport to ER **Hospital Encounter** Hospital Discharge Hospital Admission ER Visit ER Visit (Unattributed Member) Authorized Inpatient Stay **Assessment Tools** The Geriatric Depression Scale (GDS) Patient Health Questionnaire (PHQ-9) Edinburgh Postnatal Depression Scale (EPDS)	
Findings: HCI demonstrated the Connect 4 Care care coordination system used by HCI to collect and communicate *some* of the required components of the care coordination tool to the delegated care coordination entities—"accountable care coordination entities"—which perform care coordination for individual members. However, each accountable care coordination entity maintains its own electronic care coordination system which includes the full care coordination tool for each member. Staff members stated that HCI performs a pre-delegation assessment of each entity to ensure that each delegate's care coordination tool includes the required elements. While the pre-delegation assessment tool included, "How do you document care coordination? Please provide policy or tool," the assessment did not reflect that HCI reviews each delegate's care coordination tool to ensure collection of the minimum required elements. In addition, the PCMP Full Accountable Agreement did not detail the elements required to be included in the electronic care coordination tool.		
Required Actions: HCI must implement mechanisms to ensure that the electronic care coordination tool used by each accountable care coordination entity includes the minimum required elements outlined in the RAE contract.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The RAE ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(6)* Contract: 20.B Amendment 1: Exhibit B1—11.3.7.11, 15.2.1.2.2	**Documents Submitted/Location Within Documents:** 1. Beacon_InfoSecurityBrochure_2RAE-entire doc 2. 262L_CareCoordination_2RAE-Pages 4-5 3. ClinicalAuditTool_2RAE-Section A 4. Care CoordinationInternalAuditTool_2RAE-Section-Pg18 5. QM 319.04_2RAE-entire policy **Description of Process:** Beacon Information security practices follows industry best practices and compliance framework based on HIPAA, HITRUST, NIST and the ISO 27001:2013 standard. Beacon Health Options (National) undergoes stringent audits like Type II SOC1, Type II SOC2, Verizon Business/Cybertrust Security Management Program and accreditation programs such as NCQA, URAC, and MOS DIACAP/RMF. Beacon_InfoSecurityBrochure_2RAE outlines rigorous security measures inherent in the design, implementation, and day-to-day operations of Beacon as part of our continuing commitment to security of information and HIPAA compliance. This document is intended to provide a glimpse into the world of information security within Beacon in a day-today environment and help assuage questions related to security, compliance, privacy and business continuity. 262L_CareCoordination_2RAE -pages 4-5 reflects expectations that Beacon Health Options will coordinate services and share relevant treatment information identified groups or parties, as appropriate to ensure collaboration of care and ensuring that all communications with other providers are in accord with all	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	applicable Federal and State requirements related to the protection of individually identifiable health information. These requirements include those specifically identified in 45 CFR, parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. Providers are monitored on compliance with this requirement through existing audit procedures see ClinicalAuditTool_2RAE-Section A and through Care CoordinationInternalAuditTool-2RAE-Section-P18 QM 319.04_2RAE policy outlines that all network practitioners are required to maintain records in compliance with, accrediting, and regulatory body standards, which require that member treatment records are maintained in a secure manner and includes current, comprehensive, detailed, organized, and legible writing and/or electronic organization to promote effective member care and reflect acceptable standards during the quality record review process. Treatment records are subject to audit/reviews.	

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	9
				Total Score ÷ Total Applicable		=	82%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit B1—7.3.7.1–2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE, entire policy **Description of Process:** Health Colorado Inc. (HCI) adheres to our Member Rights and Responsibilities Policy, (see 304L_MemberRandRPolicy_2RAE) which guides our position on protecting member rights. The Members Rights and Responsibilities policy meets all state and federal regulations and contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit B1—7.3.7.3	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE (page 10) 2. Employee AttestationofMemberRights_2RAE 3. ProviderContract_2RAE, pages 13, 22 4. Feedback Database_HCI, page 2 5. ProviderHandbook_2RAE, page 17 *misc. 6. TownHall_HCI, page 6 *misc. 7. TownHallSigninsheets_HCI, entire document *misc. **Description of Process:** HCI follows Beacon's Member Rights and Responsibilities Policy and requests that employees read and sign a copy of the policy (see page 10 of 304_Member RandRPolicy_2RAE. For examples of signed attestations, see Employee Attestation of MemberRights_2RAE. Employees attest that they have read the Members Rights and Responsibilities policy and that they are expected to treat Members in a manner that respects their rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	If a Member believes that their rights have been violated, they can make a complaint at any time by phone, letter, in person, or an email. A complaint is monitored through the complaints process. There is a complaint category that is specific to a violation of Member Rights (see Feedback Database_HCI, page 2). There is a non-discrimination notice alerting Members that the RAE follows applicable federal and state laws on our website. (See Non Discrimination Statement). The RAE has information about Member Rights and Responsibilities in the Provider Handbook (see page 17). There is a description in the Providers Contract that they will comply with state and federal laws relating to Member's confidentiality rights (See ProviderContract_2RAE, pages 13 and 22). The RAE hosts town halls and educates providers on Member Rights and Responsibilities. See Town Hall_HCI and TownHallSigninSheets_HCI.	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE, pages 1-3 2. 307L_MemberInfoReqPolicy_2RAE, page 2*misc. **Description of Process:** Health Colorado follows Beacon's policies and procedures to ensure that each Member is guaranteed rights. See highlighted portions of 304L_MemberRandRPolicy_2RAE, pages 1-4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit B1—7.3.7.2.1–6	HCI follows the Member Information Requirements Policy and Procedures to ensure that Members are given information in accordance with the requirements stated in 42 CFR438.10. See 307L_MemberInfoReqPolicy_2RAE, page 2.	
4. The RAE ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit B1—7.3.7.2.7	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE, page 2 2. ProviderHandbook_2RAE, page 19 *misc. 3. LunchandLearn_HCI *misc. 4. LunchandLearn_MemberResponsibilities_HCI 5. Complaint Guide_HCI, page 2 6. EvidenceofPostersHung_HCI 7. RightsandResponsibilitiesPoster_ HCI 8. RightsandResponsibilitiesPosterSpanish_HCI	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: Health Colorado delegates the oversight of this requirement to Beacon Health Options. Beacon's Member Services Department is responsible to uphold member rights without retaliation to the Member. This is done through member and provider education and through the complaint process. Health Colorado follows Beacon's Member Rights and Responsibilities Policy to ensure that each member is free to exercise their rights and that they will not be treated adversely by the RAE, network providers, or the state Medicaid agency (Healthcare, Policy, and Financing). See 304L_MemberRandRPolicy_2RAE. The ProviderHandbook_2RAE outlines on page 19 that Members will not lose their Health First Colorado benefits for filing a complaint nor be treated differently for filing a complaint, nor be restricted access to services. Members are made aware of their rights and responsibilities through several avenues. There is a Rights and Responsibilities document on our website (see Rights and Responsibilities Document). In this document, the ninth item is "Use your rights and or file a complaint without fear of being treated poorly." This document is available in both English and Spanish on HCI's website (see Health Colorado and Health Colorado-Spanish). Member Rights and Responsibilities posters and How to File a Complaint posters are distributed at partner sites, provider's offices, and at the RAE in both English and Spanish. See Rights	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and Responsibilities Poster_HCI and Rights and Responsibilities Poster Spanish_HCI. (See EvidenceofPostersHung_HCI). Health Colorado also hosts Lunch and Learns for Members to educate them on their rights and responsibilities. Health Colorado hosted one of these events on August 28th which addressed the question, "What do I need to know about my responsibilities in my health plan?" All members present at this event stated that they believe that Members have responsibilities for their health care. See the flyer to advertise this event. Lunch and Learn_Member Responsibilities_HCI. There is a complaint guide on the website (See Health Colorado website) which explains that Members will not be treated differently for making a complaint (i.e., exercising their rights). This is available in both English and Spanish. See Complaint Guide_HealthColorado, page 2.	
5. The RAE complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act.	**Documents Submitted/Location Within Documents:** 1. 310L_NonDiscriminationPolicy_2RAE, page 1 2. 304L_MemberRandRPolicy_2RAE, page 5 3. FeedbackDatabase_HCI, page 2 **Description of Process:** Health Colorado follows Beacon's Member Rights and Responsibilities Policy and Non-Discrimination Policy to comply with other federal and State laws that pertain to Member rights. See 310L_NonDiscriminationPolicy_2RAE, also 304L_MemberRandRPolicy_2RAE.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.100(d) Contract: 21.U	Right violations are monitored through the complaint process. Rights violations is one of the complaint categories in our complaint reporting system and we are able to pull a report of complaints related to member rights and take action if any is warranted. If a Member believes that their rights have been violated, they can make a complaint at any time by phone, letter, in person, or an email. Beacon's Member Engagement Specialist will listen to the Members complaint about their rights being violated and will investigate the complaint and follow up with a Complaint Resolution Letter. Beacon tracks all complaints, including complaints about any rights being violated in our Feedback Database (see Feedback Database_HCI).	
6. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: 20.A Exhibit A—2.c and 3.a	**Documents Submitted/Location Within Documents:** 1. 33.4_UsesandDisclosureofPHI policy_2RAE, page 1*misc. 2. 304L_MemberRandRPolicy_2RAE, pages 2-3, 8-9 3. PCMPFullAccountableAgreement_2RAE, page 10 *misc. 4. HIPAAPrivacy_HCI, page 1 *misc. 5. HIPAASecurity_HCI, entire document *misc. 6. HIPAA_HCI, entire document *misc. **Description of Process:** HCI 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).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI follows Beacon's 33.4_UsesandDisclosureofPHI policy_2RAE which is the policy that addresses disclosures in accordance with privacy rules. On page one (1) the policy states that we may use and disclose PHI only as permitted or required by federal privacy law and relevant state law. This would include 45 CFR parts 160 and 164. HCI follows 304L_MemberRandRPolicy which states on page 8 that the confidentiality policies and procedures must conform to all federal and state confidentiality laws and regulations (See G. i.) In this same policy, it states that Members have the right to request and obtain a copy of their PHI and ask HCI to amend or correct their PHI (see pages 8, g/iv/2 and3). On page 2 of this same policy, it states that members will be furnished with health care services in accordance with requirements for timely access and medically necessary coordinated care (see xiii). The entirety of the RAE Compliance Plan contains written policies, procedures and standards of conduct which articulate the RAE's commitment and ability to comply with all applicable contract, federal and State requirements. HCI requires Primary Care Medical Providers who are accountable providers to sign an agreement. (See PCMPFullAccountableAgreement_2RAE). On page 10 (10) the agreement states that the PCMP is and remains responsible for compliance with all applicable provisions of state and federal law, which includes a Member's medical record.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI follows the following policies: • HIPAAPrivacy_HCI states on page one (1) that HCI will ensure the privacy of an individual's health and personal information as requirement by federal and state regulations. • HIPAASecurity_HCI outlines how Health Colorado will protect Members PHI; • HIPAA_HCI outlines that HCI will designate a Privacy Office to ensure Member's privacy.	
7. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. • The difference between institution wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member	**Documents Submitted/Location Within Documents:** 1. 269L_AdvanceDirectivesPolicy_2RAE, entire policy 2. MemberLetter_HCI, entire document 3. TownHall_HCI, page 12 *misc. 4. TownHallSigninSheets_HCI, entire document *misc. **Description of Process:** HCI has a written policy and procedure relating to Advance Directives. A copy of this policy is located on our website under Advance Directives/Living Will. Click on Advance Directives Policy. We have also attached 269L_AdvanceDirectivesPolicy_2RAE to review the policy in its entirety demonstrate that we have a policy in place for all adult individuals receiving care through the RAE. HCI sends an annual mailing to Members directing them to the website to find out about Advance Directives. Members, Providers and Stakeholders can access HCI's website, Advance Directives/Living Will, and have access to links for Colorado Medical Advance Directives, Five Wishes, and Achieve	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives. • Provisions for community education regarding advance directives that include:	Solutions articles on Advance Directives. There is information about what constitutes an Advance Directive with an emphasis that an Advance Directive is designed to enhance an incapacitated individual's control over medical treatment. We have provided a link to Colorado's website with applicable State Law on Advance Directives. The RAE collaborates with providers at town hall meetings to identify how providers work with Members regarding Advance Directives. See TownHall_HCI and TownHall SigninSheets_HCI.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.1.3–7		

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. 1. The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 1: Exhibit B1—7.2.5, 7.3.6.1	**Documents Submitted/Location Within Documents:** 1. IT302.3 _508ComplianceofExternalWebSitesPolicy_2RAE-entire policy 2. 307L_MemberInfoReqPolicy_2RAE Page 1, 2 and 3 *misc. 3. WebsiteComplianceCheck_HCI 4. MeetingMinutes_HCI, Page 3 5. WebsiteReview_HCI, entire document **Description of Process:** HCI has delegated website management to Beacon Health Options. Beacon follows IT302.3_508 Compliance of External Websites Policy for the website reviews. This policy addresses our website being readily accessible. On page 1, I A, the policy states that Beacon's external websites must adhere and meet 508 compliance standards. On page 2, IIC, it states that under Section 508, agencies must give disabled employees and members of the public access to information that is comparable to the access available to others. On page 2, IID, the policy addresses World Wide Web Consortium (W3C) that leads the website to its full potential. On page 2, III, the purpose of the policy is to publish procedures for the development of external web sites to ensure that 508 compliance is maintained. On page 2, IV A, the procedures have Priority 1 checklist items. Priority 1 items must be addressed and are required to make a site accessible. On page 4, the policy has Priority 2 Checklist items which should be addressed to make the site accessible, but these items are not required. On Page 6, the policy lists Priority 3 Checklist items These items could be addressed to improve the accessibility of a site. Our electronic information complies with 508 guidelines and W3C's Web	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Content Accessibility Guidelines. Beacon regularly runs 508/Web Content Accessibility Guidelines (WCAC) scans on their websites to resolve accessibility issues they can control (they cannot control PDF content). Beacon sends the 508/WCAG reports monthly so that HCI is aware of what needs to be resolved to remediate any issues with accessing PDF documents. Please see Website Compliance Check_HCI to review our automated compliance report. Beacon National corrects the majority of these accessibility issues. HCI also follows 307L_Member Information Requirements Policy_2RAE which states in I A that Member materials will be easily understood, culturally relevant, and meaningful to Members and their families. In this same policy under IB, Member materials are written at an appropriate reading level so that they are clear, concise and understandable to the representative population. In IIB, HCI describes their use of the Flesch-Kinkaid software which ascertains the minimum education level required to understand materials. See our Non-Discrimination Notice which is located on our website screenshot which addresses discrimination to adhere to Section 504 of the Rehabilitation Act. HCI's Member Services Subcommittee reviews Member materials and requests that Advocates review Member materials with Members. See page three of our MeetingMinutes_HCI. One member provided their thoughtful recommendations for the website (see WebsiteReview_HCI).	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit B1—7.3.6.1	**Documents Submitted/Location Within Documents:** 1. Wellpass_HCI, entire document 2. WebsiteScavangerHunt_HCI, entire document 3. CareCoordination_Minutes 7.19.18_HCI entire document 4. CareCoordinationMinutes 8.16.18_HCI entire document **Description of Process:** HCI launched a texting campaign in January 2019 that is designed to help Members understand the requirements and benefits of the plan. The name of the texting campaign is called Wellpass. There are several topics which are texted to Members to help them learn about their benefits. These include: Member Handbook and Website Link; Well Child Visits, Nurse Help Line, Member Rights, Coverage, Community Resources; Primary Care, Adult Annual Physicals, Suicide, Advance Directives, Vaccinations, Mental Health, ER Avoidance, Insurance Card, Member Information, and Care Management. Please see Wellpass_HCI for the specific text scripts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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	**Documents Submitted/Location Within Documents:** 1. ManagedCareTerminology_2RAE, entire document 2. HealthFirstColorado_StyleGuide_2RAE, page 7 **Description of Process:** HCI understands the need for consistency in the information that is provided to our Members between the state and our RAE. HCI has researched managed care definitions provided by Healthcare, Policy, and Financing in the Health First Colorado's (Colorado's Medicaid Program) Member Handbook and developed a Managed	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 1: Exhibit B1—3.6, 7.3.4	Care Terminology resource for our members which is located on our website (see Managed Care Terminology). It is located under the Resource tab/Managed Care Terminology. When you click on the Managed Care Terminology icon, Members can access a PDF Document with the definitions for the terms (see ManagedCareTerminology_2RAE). HCI uses the Member Handbook developed by the State of Colorado, Department of Healthcare, Policy, and Financing (HCPF). This is displayed on the main page of our website Health Colorado. HCI models member notices after Health First Colorado's style guide. On page six (6) of the style guide, we have highlighted the specific instructions on how to message Members. Please see the same messaging which is listed on our website. See What is a Regional Organization?	

Findings:
The Department has not provided a list of these definitions to the RAEs, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the RAE to be aware of this requirement and to consistently use definitions from the Department when available.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18-point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats.	**Documents Submitted/Location Within Documents:** 1. DefinitionofPrevalentNonEnglishSpeakers_2RAE, page 8 2. NonEnglishSpeakingSummary_HCI 3. ProviderDirectory_HCI, page 1 4. AppealReceiptLetter_HCI, page 1 5. ComplaintReceiptLetter_HCI, page 1 6. ComplaintGuide_HCI, page 1 7. AppealGuide_HCI. Page 1 8. State Fair Hearing Guide_HCI, page 1 9. NoticeofAdverseBenefitDeterminationLetter_HCI, page 1 10. ProviderTerm_HCI, page 1 11. AppealDecisionLetter_HCI, page 1 12. ComplaintResolutionLetter_HCI page 1 13. 307L_MemberInfoReqPolicy_2RAE, entire policy *misc. 14. 311L_HandlingCallsWithLimitedEnglishSpeakingMembersPolicy_2RAE, entire policy 15. MeetingMinutes_HCI, page 3 **Description of Process:** HCI researched the prevalent non-English language spoken in our region. According to Rule #MSB 17-01-18-A in the Revision to the Medical Assistance Rule Concerning Managed care, "prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the state. According to Data USA, there are 16.56% of Non-English Speaking members in Region 4. In 2015, the most common non-English language spoken in Colorado was Spanish.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit B1—7.2.7.3–9; 7.3.13.3	10.5% of Colorado's overall population are native Spanish speakers, followed by German at .45% and Chinese at .41%. Based on this information, the most prevalent non-English language in Colorado is Spanish. HCI has over one-hundred (100) languages accessible through Google Translate available on our website (Health Colorado). In the upper right hand corner of the website, you can click on the flag to access other languages. HCI has uploaded a copy of Health First Colorado Member Handbook Spanish on the main page of our website. Members can access this handbook on our main page by clicking on the handbook icon. (See Spanish Member Handbook. HCI has taglines in large print and prevalent non-English language which describes how a Member can request auxiliary aids and services, written translation, or oral interpretation. We include our toll free and TTY/TDY customer service number on our website. See Health Colorado's website in the upper right hand corner. HCI explains the availability of materials in alternative formats at no charge to the member. See Member Tab. We have included several examples of materials that are critical for Members to obtain services including provider directories, appeal, complaint, notice of adverse benefit determination, and letters to Member of provider terminating. See Appeal Receipt Letter_HCI, Complaint Receipt Ack Letter_HCI, Notice of Adverse Benefit Determination Letter_HCI, ProviderTerm_HCI, Appeal Decision Letter_HCI, Complaint Resolution Letter_HCI, Complaint Guide_HCI, Appeal Guide_HCI, and State Fair Hearing Guide_HCI.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI follows the Member Material policy (307L_Member Info Req Policy_2RAE) to ensure that Member materials are accurate, easily understood, culturally relevant, clear, available in other languages at no charge to the member and available in alternative formats. HCI runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. See 307L_MemberInfoReqPolicy_2RAE page 2 for readability testing guidelines. HCI follows policy (311L_Handing Calls for Limited English Speaking Members_2RAE) which guides our calls with limited English speaking members. We utilize Voiance® translation line which allows us to expediently connect Members with an interpreter in over 150 languages. The Member Services Subcommittee reviews Member materials and requests that Advocates review Member materials with Members. See MeetingMinutes_HCI, page 3.	
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed.	**Documents Submitted/Location Within Documents:** 1. IT302.3_508ComplianceofExternalWebSitesPolicy_2RAE, entire policy 2. WebsiteComplianceCheck_HCI, entire document 3. WebsiteUpdateRequests_2RAE, entire document 4. 307L_MemberInfoReqPolicy_2RAE, page 3 *misc. **Description of Process:** HCI does make information available to our Members electronically on our website, Health Colorado. HCI has delegated the execution of website content and monitoring to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	Beacon Health Options. Beacon has a policy to guide the requirements of being readily accessible. See IT302.3_508 Compliance of External Websites_2RAE. Beacon regularly runs 508/WCAG scans for their websites to resolve accessibility issues they can control (they cannot control PDF content). Beacon runs all PDF documents through an accessibility scan before uploading the content to the website. The 508/WCAG reports are shared monthly so that everyone is aware of what needs to be resolved and so that accessible PDFs and content can be provided to remediate the issues. See Website Compliance Check_HCI. Beacon National corrects the majority of these accessibility issues. HCI reviews content on a monthly basis to update relevant information for our Members. See WebsiteUpdateRequests_2RAE. We inform Members that they can request any information at no charge upon request and that will provide this information to them within five working days. Please see Member Tab for this information. To demonstrate that that our information can be electronically retained and printed, we have attached Provider Directory_HCI which was printed from the website. HCI has a Member Material policy (307L_Member Info Req Policy_2RAE) which we follow to ensure that Member materials are accurate, easily understood, culturally relevant, clear, available in other languages at no charge to the member and available in alternative formats. HCI runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. See 307L_MemberInfoReqPolicy_2RAE page 2 for readability testing guidelines.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: Exhibit B1—None	HCI has information about Member's prescription fomulary available on our website. See Resources under Prescription Information. Magellan's RX Management website is listed on the Magellan RX's website. We inform Members that anything on our website can be sent to them in paper form. See Member Tab for evidence.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The RAE makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The RAE notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and informs how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit B1—7.2.6.2–4	**Documents Submitted/Location Within Documents:** 1. AppealReceiptLetter_HCI, page 1 2. ComplaintReceiptLetter_HCI, page 1 3. Notice of Adverse Benefit DeterminationLetter_HCI, page 1 4. 311L_HandlingCallswithLimitedEnglishSpeakingMembers_2RAE – entire document 5. EvidenceofInterpretationServices_2RAE, entire document 6. BillforInterpretationServices_HCI, entire document 7. 307L_MemberInfoReqPolicy_2RAE, entire policy *misc. 8. ProviderHandbook_2RAE, pages 17 *misc. **Description of Process:** HCI makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and how Members can access them. This includes the use of auxiliary aids such as TTY/TDY and American Sign Language. This information is embedded in the taglines for all of HCI's correspondence which we send Members. See Appeal Receipt Letter_HCI, Complaint Receipt Letter_HCI, and Notice of Adverse Benefit Determination Letter_HCI for a few examples.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's phone numbers are in a prominent place on our website and in our Member brochures. Please see Health Colorado website in the upper left hand corner. We inform Members that they have these services available to them at no charge on our website. Please see Member Tab. HCI follows the policy 311L_Handling Calls with Limited English Speaking Members_2RAE to ensure that members have access to oral interpretation for any language free of charge. This policy is provided as evidence for compliance with this standard because most requests for oral interpretation or written translation of Member materials are made telephonically. We have a guide attached to the policy, "Working with Interpreters," which guides staff members on how to use an interpreter. HCI does provide brief education about using interpreters prior to the interpreter appointment. Beacon Health Options contracts with Voiance® to provide interpreter services for our members in over 150 languages. Voiance is a leading provider of language interpreting services and their services are available 24/7. This service is used for members calling into our Access to Care Line, or members who request an oral interpretation of written materials into a language other than English or Spanish. This service allows us to provide interpreter services in "real time." Page 2 of the policy 311L_Handling Calls with Limited English Speaking Members_2RAE outlines how to use Voiance. See EvidenceofInterpretationServices_2RAE. HCI uses Relay Colorado for members who are deaf or hard of hearing. If interpreter services will be needed for clinical services,	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI will find a provider in the network who is proficient in sign language, or contract with a sign language interpreter if no providers are available in the region. Policy 311L_Handling Calls with Limited English Speaking Members_2RAE outlines how to use Relay Colorado on page 2 and 3. The policy outlines on page three the process for when a provider and or PIAC/MEAC chair needs an interpreter for a meeting. One Member who attends the PIAC/MEAC meetings is hearing impaired. Health Colorado obtained American Sign Language services to accommodate this Member. Please see BillforInterpretationServices_HCI. Providers are made aware of their responsibility to offer interpreter services for Member in the Provider Handbook_2RAE on page 17. It also explains that providers can contact HCI to receive help with this. HCI also provides a link for free sign language interpreting services, RISP, for rural counties. All nineteen (19) counties are eligible for this program. Please see the Resource Tab. HCI follows the policy, 307L_Member Info Req Policy_2RAE. The policy outlines on page 3 that Member materials are orally translated into other languages by request at no charge to the member. The policy states that Member Materials are available in alternative formats for Members who have communication disabilities free of charge. Alternative formats include large type, audio tape, TTY/TDY, and American Sign Language.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit B1—7.2.6.1, 7.2.6.5	**Documents Submitted/Location Within Documents:** 1. 311L_HandlingCallswithLimitedEnglishSpeakingMembers_2 RAE, pages 1,2 and 5-6 2. ProviderHandbook_2RAE, page 17 *misc. 3. ComplaintGuide_HCI, page 2 4. Appeal Guide_HCI, page 2 **Description of Process:** HCI ensures that language assistance is provided at all points of contact for a Member, in a timely manner, and during all hours of operation. HCI's customer service telephone number ensures easy 24/7 hour access for interpreter or bi-lingual services. HCI follows the policy 311L_ Handling Calls with Limited English Speaking Members_2RAE. On page 1, it states that language translation services are available 24/7, 365 days a year. On page 2, the process for how to use the translation line is outlined. On pages 5-6, there is a guide attached to the policy, "Working with Interpreters" which directs staff members on how to use an interpreter. HCI does provide brief education about using interpreters prior to the interpreter appointment. Beacon Health Options contracts with Voiance® to provide interpreter services for our members in over 150 languages. Voiance is a leading provider of language interpreting services and their services are available 24/7. See their website by clicking on VOIANCE. This service is used for members who call our Customer Service number. This service allows us to provide interpreter services in "real time." See Evidence of Using Interpretation Services_2RAE.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	If a Member requests an oral interpretation of written materials into a language other than English or Spanish, we utilize Voiance to meet this need. HCI may use Voiance® initially to determine the extent of the need for further interpreter services when a Member needs to facilitate communication between two parties. If we ascertain that interpreter services will be needed beyond the initial call, the request is forwarded to the Member Engagement Specialist who will request interpretation services. On page 3 of 311L_Handling Calls with Limited English Speaking Members_2RAE, it outlines this process. If interpretation services are needed for an administrative reason (complaints or appeals) the Member Engagement Specialist will connect with the interpreter and set an appointment(s) to discuss the complaint or appeal. See page 2 of ComplaintGuide_HCI, page 2 of AppealGuide_HCI. These guides are in English and Spanish on our website. See Complaints and Appeals. When a Member requires language interpretation for clinical services, a Provider can contact HCI. The Member Engagement Specialist will assist in the provider and will connect them with Asian Pacific Center. Asian Pacific Center has interpreters available for face-to-face, telephonic, or Skype interpretation in approximately seventy (70) languages. You can visit their website Asian Pacific Center. Providers can find out about this in the provider handbook on page 17. See Provider Handbook_2RAE.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI uses RelayColorado for members who are Deaf or hard of hearing. If interpreter services will be needed for clinical services, the Member Engagement Specialist will find a provider in the network who is proficient in sign language, or contract with a sign language interpreter if no providers are available in the region.	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit B1--None	**Documents Submitted/Location Within Documents:** 1. Wellpass_HCI, entire document **Description of Process:** HCI has delegated Beacon Health Options to run monthly reports of members who are new to HCI. These members will be sent a text which states, "Want a copy of your member handbook? Need to find a doctor? Visit www.healthcoloradorae.com to check out all of the information and tools we offer. A copy of the member handbook is available on the main page of our website. See Health Colorado. See Wellpass_HCI for content for text messaging.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: HCI does not produce a RAE-specific member handbook.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 1: Exhibit B1--None	**Documents Submitted/Location Within Documents:** 1. 307L_MemberInfoReqPolicy_2RAE, page 4 *misc. **Description of Process:** HCI provides updates to Members regarding any significant change on our website. See Updates on Benefits. Any changes that impact a Member's benefits are uploaded to this site. HCI follows 307L Member Info Req Policy_2 RAE which states that the RAE will update their website at least thirty (30) days before an intended effective date of significant changes made by the state on page 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 1: Exhibit B1—7.3.8.1	**Documents Submitted/Location Within Documents:** 1. 307L_MemberInfoReqPolicy_2RAE_ page 4 *misc. 2. RAEHandbookInsert_HCI, entire document **Description of Process:** HCI follows the 307L_Member Information Requirements Policy which states that the RAE will update their contact information for the Member handbook on page 4. This information was provided to the State as per policy and was reviewed for 42 CFR 438.10(g) requirements. HCI does not have any RAE specific member handbook.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: HCI does not produce a RAE-specific member handbook.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 1: Exhibit B1—7.3.10.1	**Documents Submitted/Location Within Documents:** 1. ProviderTerminationWorkflow_2RAE - entire document 2. WeeklyPendingDisenrollment_none_2RAE, entire document 3. WeeklyPendingDisnerollment_2RAE, entire document 4. ProviderTerm_HCI, entire document **Description of Process:** HCI has delegated Beacon Health Options to notify Members when Providers dis-enroll from the Network. Beacon makes a good faith effort to notify Members within 15 days upon receipt of the termination notice. Beacon's Knowledge Management and Reporting team (KMAR) developed an automatic disenrollment Report (see Weekly Pending Disenrollment_NONE_2RAE for an example of the email that is sent out on a weekly basis.) This document has no Members disenrolling. For an example of the report with a provider disenrolling from the network, see Weekly Pending Disenrollment_2RAE. The report outlines providers who are dis-enrolling or are pending disenrollment from the network. This report is sent on a weekly basis via e-mail to Member Services and Provider Relations. The automated report includes the provider's name, date of disenrollment, and lists members who are currently seeing or have seen the provider in the last 6 months. Beacon's Provider Relations staff will verify if the provider is truly dis-enrolling prior to sending out notifications to Members. Providers may end up this report for several reasons such as: 1) Providers who have not returned re-credentialing paperwork; 2) Providers who have not re-validated with the State; 3) Providers who have not filed a change of address; 4) Providers who have not	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	met other administrative requirements; 5) Providers who have had a serious violation; or 6) Providers who have informed Beacon that they are voluntarily withdrawing from the Network. This report can be up to 90 days before a provider officially gets dis-enrolled. This time frame allows providers time to fulfill administrative requirements or to appeal a pending disenrollment decision. When a provider has exhausted all appeals, we receive a final report which contains Members who will need to have their care transitioned to a new provider. This is approximately 45 days before final disenrollment. However, there are times a provider moves, resigns from the network, or leaves the network in some other way. Provider Relations expediently informs Member Services when a provider is voluntarily dis-enrolling from the network. Member Services sends the Member a letter (see ProviderTerm_HCI) to any Member who had been seeing the dis-enrolled provider during the previous six months. A letter is sent within 15 days of dis-enrollment when possible. Situations where we would not inform members within the 15-day window would be when the provider informs us after they have closed their practice, or upon the death of a provider. In these cases, we inform members as soon as possible after we receive the information.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit B1—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	**Documents Submitted/Location Within Documents:** 1. WebsiteUpdateRequests_2RAE, entire document 2. JobAidforWebsiteUpdates_2RAE, entire document 3. WebsiteUpdatesWorkflow_2RAE, entire document **Description of Process:** HCI has delegated the creation and oversight of their website to Beacon Health Options. Beacon Health Options has developed a website and maintains this website on a weekly basis. This website is customized and comprehensive and includes the following on the main page: Health First Colorado Nurse Line, the Colorado Crisis Services information, a link to Health First Colorado and a link to the Member handbook in both Spanish and English. Click on Health Colorado to view the website and find this information. Under Member Tab a Member can find information on Rights and Responsibilities and the Complaint and Appeal process. A member may find a copy of their provider directory by clicking Find A Provider where the provider directory is located. The general functions of the RAE can be seen by clicking What is a Regional Organization? The Access to Care Standards can be found by clicking Clinical Tools. The website was originally going to be maintained on a monthly basis, however, Beacon saw the need to review updates on a weekly basis due to the wealth of information we want to make available to Members, Providers, and Stakeholders. We developed the WebsiteUpdatesWorkflow_2RAE to cross train several departments that need to update the website. We developed the JobAidforWebsiteUpdates_2RAE to outline the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	process to make updates. Included in this process is ensuring our PDF documents are 508 compliant. For evidence of information that we have uploaded to the site, see WebsiteUpdateRequests_2RAE.	
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 (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar*	**Documents Submitted/Location Within Documents:** 1. EvidenceofProviderDirectoryUploadedMonthly_2RAE, page 2 2. MonthlyUploadDirectory_2RAE, entire document 3. ProviderDirectory_HCI, entire document **Description of Process:** HCI has delegated provider oversight to Beacon Health Options. Beacon's Provider Relations Department ensures the provider directory is available to our members in paper or electronic means. The Provider Directory is a list of contracted primary care providers, behavioral health providers, and hospitals. Providers/Facilities street address, telephone number, website address, linguistic capabilities (including American Sign Language), specialties, cultural competency training, if new patients are being accepted and ADA compliance. Members are able to obtain a copy of our contracted providers on our website and print off a copy. See Find A Provider. When a Member clicks on this tab, they have options to view the provider directory or use other links to find a PCP, dentist, specialist, or pharmacist. Members can also use Referral Connect to find a behavioral health provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
days after the contractor receives updated provider information. *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit B1—7.3.9.1.6	Members can contact our toll free number and request a copy of the Provider directory. Members can also search in Referral Connect and search providers by specialist, American Sign Language, handicapped accessible, near public transportation, and providers accepting new patients. Many Members choose to call into the call center to request Health First Colorado providers in their vicinity. A Clinical Service Assistant (CSA) will use our Referral Connect system to find providers near the Member. A CSA can search several fields including specialties, language, gender preference, and access for disabilities. If a Member has a certain request for specialized equipment for their disability, a Member Services team member would reach out to the PCP to see if they can accommodate the Member's request. Providers can update their information on Provider Connect. Updated information can be phone numbers, addresses, specialties, whether they are currently accepting new patients, or linguistic capabilities, or access for physical disabilities. Providers notify Beacon when they are unable to accept new Members. Provider Relations staff will list their practice as full and remove these providers from the next provider directory upload. Provider Relations has not received an example of request under the RAE to share. Beacon will use Providers' information to update the Provider Directory, including any of these changes on a monthly basis	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	according to our Standard Operating Procedure. Information included in our paper provider directory is updated at least monthly, and electronic provider directories are updated no later than 30 calendar days after the Contractor receives updated provider information. See Evidence of Provider Directory Uploaded Monthly_2RAE. Provider Relations has a monthly Data Management & Analysis Task Tracker (DMATT) ticket to update the provider directory on a monthly basis. Once this directory is updated, it is uploaded to our website. See Monthly Upload Directory_2RAE.	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	**Documents Submitted/Location Within Documents:** 1. ProviderDirectory_HCI – entire document 2. IT302.3_508ComplianceofExternalWebSitesPolicy_2RAE, pages 2-3 3. WebsiteComplianceCheck_HCI **Description of Process:** HCI has delegated to Beacon the responsibility to guarantee Provider Directories are available on the Health Colorado website in a machine-readable file and format. For evidence of the directory, please click Find A Provider and select provider directory to confirm that the directory is in a format that can be easily processed by a computer. We have also printed out a version of the directory. Please see Provider Directory_HCI. Beacon follows IT302.2_ 508 Compliance of External Websites Policy_2RAE to ensure that documents are machine readable.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Please refer to Priority 1 Checklist (items which must be addressed and are required to make a site accessible) on pages 2-3. Beacon runs 508/WCAG website scans monthly to resolve accessibility issues. The 508/WCAG reports is reviewed by a Beacon staff member to resolve and remediate any issues. See Website Compliance Check_HCI. Beacon runs Adobe Acrobat Pro on the provider directory on a monthly basis prior to posting the directory on the website.	
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • RAE's single toll-free customer service phone number. • RAE's email address. • RAE's website address. • 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.	**Documents Submitted/Location Within Documents:** 1. Brochure_HCI entire document *misc. 2. InformationOneStop_HCI, entire document 3. ComplaintReceiptLetter_HCI, entire document 4. Wellpass_HCI, entire document **Description of Process:** HCI has developed electronic and written materials for distribution for newly enrolled and existing members. The name of the website is: www.healthcoloradorae.com. For evidence of written materials, please see Brochure_HCI. HCI's single toll free customer service phone number and state relay number are listed in both the brochure and in the upper left hand corner of the website and under Contact Tab. The email address is listed under the Contact Tab and on the inside of the brochure. HCI also developed flyers with the website address to be placed at provider's offices, shelters, libraries, mental health centers, etc. See InformationOneStop_HCI. HCI also sends Members texts with HCI's phone number and website address. See Wellpass_HCI.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 1: Exhibit B1—7.3.6.1	The basic features HCI's PCCM and PIHP, the service area covered, our responsibility for care coordination and the requirement of HCI to provide adequate access to behavioral health services included in the plan including network adequacy standards can be found under What is a Regional Organization? Care Coordination information can also be found on the Care Coordination Tab. Information about which populations are subject to mandatory enrollment into the ACC can be found at Member Attribution on our website. HCI uses the information which was developed by Healthcare, Policy and Financing. Medicaid benefits including those in the capitated behavioral health benefits, and how to obtain counseling and referral services, any restrictions on freedom of choice, and if there are services we do not cover because of moral or religious objections can be found on HCI's Benefits and Services link. HCI's quality and performance indicators can be found on the Quality Tab. We encourage members to take a survey which monitors if members are happy with their healthcare. See Want to Improve Your Health? Survey.	
17. The RAE will annually mail each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit B1—7.3.8.1	**Documents Submitted/Location Within Documents:** 1. AppealReceiptLetter_HCI, page 2 2. ComplaintReceiptLetter_HCI, page 2 3. MemberLetter_HCI, entire document 4. Member Mailing Price Quote_2RAE, entire document	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: HCI will annually mail each member a notice that instructs them how to request a copy of the handbook. HCI has contacted Webb Mason for assistance with this mailing. Please see Member Mailing Price Quote_2RAE. For a copy of the mailing, please see MemberLetter_HCI. HCI also has revised all of their member mailings to include in the footer how Members can obtain a copy of the Member handbook. See AppealReceiptLetter_HCI and ComplaintReceiptLetter_HCI for a few examples.	
Findings: Effective March 20, 2019, the Department informed HSAG and each RAE that this requirement will be deleted from the RAE contract: therefore, HSAG scored this element *Not Applicable*.		
18. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided	**Documents Submitted/Location Within Documents:** 1. MemberLetter_HCI, entire document 2. InformationOneStop_HCI. Entire document 3. Wellpass_HCI, entire document 4. LunchandLearn_HCI, entire document *misc. 5. Evidence of Permission to Email_HCI, Pg. 1 and 2 **Description of Process*:*** HCI provides member information through a variety of means. The predominant method is through our website, Health Colorado. HCI sends an annual letter to member directing Members to the website to find out information about the Member Handbook, benefits, rights, and Advance Directives. There are taglines on every letter stating that HCI will provide auxiliary aids and services upon request at no charge.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit B1—None	HCI posts information on our website and informs members that they can access this information by going to the site through a mailing. See Member Handbook Mailing_HCI, Information One Stop_HCI, and Wellpass_HCI to demonstrate how Members are directed to the website. Wellpass is our texting campaign that provides Members with information about their plans and benefits. For an example of the texting campaigns, please see Wellpass_HCI. HCI will provide information through Email when we have the Member's consent to receive information by email, see Evidence of Permission to Email_HCI. HCI also provides Member information through the method of Lunch and Learns. See flyer LunchandLearn_HCI. Beacon's Member Services team goes into the community to host trainings on Member Rights, Responsibilities, or How Members Can Use Their Benefits. Members are encouraged to ask questions about their benefits during these luncheons. The Member Services team educates Members on the availability of our website and distributes HCI's brochures.	
19. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit B1—None	HCI does not have any physician incentive plans currently in place.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: HCI staff members reported that the RAE has no physician incentive plans that meet the State definition of such plans in the RAE contract.		

Results for Standard V—Member Information							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	5	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	14
			Total Score ÷ Total Applicable			=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. Contract Amendment 1: Exhibit B1—7.3.12.1	**Documents Submitted/Location Within Documents:** 1. RAE website: https://www.healthcoloradorae.com/ 2. NOABD_HCI, page 1 3. Brochure_HCI -entire document *misc. 4. LunchandLearnScavengerHunt_HCI-entire document 5. WebsiteScavangerHunt_HCI-entire document 6. InformationOneStop_HCI-entire document 7. EPSDTTrainingSignInSheet_2RAE -entire document **Description of Process:** HCI uses a variety of mechanisms to communicate with its members about the EPSDT program and how to access services. Members are informed about the EPSDT program through the Health First Colorado Member Handbook which is located on the front page of our website: https://www.healthcoloradorae.com. The website also has information about the EPSDT benefit under MEMBER TAB/Benefits and Services (see website). It is listed at the very top "*What are Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefits?*" If services have been denied to an eligible Member, the Notice of Adverse Benefit Determination letter (see NOABD_HCI) informs Members/Parents/Guardians of the potential to use EPSDT benefits to cover denied services or other recommended services that may not be covered under the capitated behavioral health benefit. Members can find out about the website through a variety of platforms. The website address is listed at the bottom of all of our	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	correspondence, on our brochures, and through posters displayed at multiple sites. We developed an Information One Stop poster to alert potential Members of the website. See InformationOneStop_HCI. This poster has been discussed at both Program Improvement Advisory Council and Member Experience Advisory Council meetings. Members brainstormed the following places to hang the posters including: community mental health centers, laundromats, post offices, Salvation Army, soup kitchens, bus stations, libraries, churches, and medical clinics. HCI hosts lunch-and-learn forums with Members to discuss benefits, rights, and responsibilities. A lunch-and-learn was held for Health Colorado Members (see LunchandLearnScavengerHunt_HCI). This was designed to help Members become familiar with their benefits by exploring our RAE website. The scavenger hunt has a section to help Members look up their EPSDT benefits. See WebsiteScavengerHunt_HCI. HCI held a training on both EPSDT benefits and Healthy Communities with Gina Robinson and Jeff Helm to educate Call Center staff, Care Coordinators, and Providers on EPSDT benefits and how to connect with a Family Health Coordinator [Held on 9/5/18]. Information on how to find a Family Health Coordinator in your area also can be found on our website (list) under COMMUNITY TAB/Healthy Communities. Call Center staff have been trained to link EPSDT eligible Members to Healthy Communities.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information: • The RAE employs Department materials to inform network providers about the benefits of well-child care and EPSDT. • The RAE ensures that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 1: Exhibit B1—7.6.2.3, 12.8.3.4; 12.9.3.4	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDT_2RAE-Entire Policy 2. BH_Procedures_2RAE—Slide 32-35 3. ProviderHandbook_2RAE, Pg. 20, 30, 40-42 *misc. 4. TownHall_HCI, page 10 *misc. 5. TownHallSigninSheets_HCI, entire document *misc. **Description of Process:** The RAE's contracted behavioral health providers are responsible for documenting the results of all screenings, assessments and examinations for members receiving behavioral health services. This requirement is stated in policy 248L_EPSDT_2RAE-Entire Policy, specifically in section IV. J: "The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered." Providers are instructed about this requirement in training about Behavioral Health Procedures, which includes specific information about EPSDT. For latest version, see BH_Procedures_2RAE—Slide 32 to 35. This training is made available to providers when they enroll in the provider network and is always available in the provider section of the RAE's website. The BHO's Provider Manual also contains information about the EPSDT program and its documentation requirements. Please see	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	highlighted areas on pp. 20, 30, and 40-42 of the ProviderHandbook_2RAE. The RAE educates providers regarding EPSDT benefits at Town Hall meetings. See TownHall_HCI and TownHallSigninSheets_HCI.	
3. The RAE shall create an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE shall train Healthy Communities contractors about the Accountable Care Collaborative and the RAE's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	**Documents Submitted/Location Within Documents:** 1. HealthyCommunitiesPresentation_HCI, entire presentation 2. HealthyCommunities_RAE_MOU_HCI, entire document **Description of Process:** The RAE has developed a presentation slide deck to train Healthy Communities contractors about the Accountable Care program and the specific responsibilities and functions of the RAE. This presentation has been or will be delivered to each of the Healthy Communities offices in the covered region. See **HealthyCommunitiesPresentation_HCI.** The RAE is developing MOUs with each Healthy Communities program office in its area. These memoranda provide detail about the expectations of each organization with respect to training, referrals, and identification of resources. A sample/template of this MOU is provided as evidence. See **HealthyCommunities_RAE_MOU_HCI** Health Colorado has already collaborated with four (4) Healthy Communities counties in region 4 to discuss strategy regarding executing the Business Associates Agreements (BAA) and a Memorandum of Understanding (MOU) with these agencies. Health Colorado staff continue the process of establishing relationships with the remaining Healthy Communities counties to execute the	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BAAs and MOUs. The primary purpose of the BAAs and the MOUs is to ensure that duplication in services is reduced and that there is a clear line between onboarding Members under twenty-one (21) and pregnant mothers. These Members are directed to Healthy Communities for engagement and Members over twenty-one (21) are directed to Health Colorado for onboarding/member engagement. A secondary purpose of BAAs and the MOUs is to strengthen the community partnerships to enhance Members' engagement in their own healthcare. The Care Coordinators have regular meetings with Healthy Communities to discuss referral processes, referrals, collaboration, prenatal care, and identifying local resources. The Care Coordinators and Family Health Coordinators collaborate on a daily basis to ensure that Members are engaged in the care they need.	
Findings: HCI met with four of five Healthy Communities (HC) contractors and presented information to educate HC contractors on RAE functions and activities. HCI had developed a template memorandum of understanding (MOU) and BAA intended to be signed with each of the Healthy Communities contractors and which included a description of the organizations' commitments to work together to define future activities related to onboarding and coordinating services for members. Staff members stated that HCI was actively engaged in discussions with each HC contractor to define more detailed processes and anticipated that the detailed activities of both HCI and the HC contractor would be attached to the MOU. Staff members anticipated that signed agreements with HC contractors would be executed by the end of April 2019. Nevertheless, at the time of on-site review, HCI did not have an executed and implemented onboarding plan defined with each HC contractor in the region.		
Required Actions: HCI must complete the process of developing and executing an onboarding plan with Healthy Communities contractors in the region.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit B1—12.8.7.6	**Documents Submitted/Location Within Documents:** 1. HCPF list of family health coordinators by county: https://www.colorado.gov/pacific/hcpf/family-health-coordinator-list or FAMILY_HEALTH_COORD_LIST_2RAE-entire document 2. HCPF EPSDT website: https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt or HCPF_EPSDT_WEBSITE_2RAE -entire document 3. HCPF PAR website: http://coloradopar.com/ or CO_PAR_WEBSITE_2RAE-entire document **Description of Process:** In addition to training providers about EPSDT requirements during their onboarding process, the RAE provides ongoing support, subject matter expertise, and resources to help providers resolve any barriers related to the EPSDT program. The RAE can provide a list of the Healthy Communities programs that serve a particular area. The RAE's call center and provider relations staff also are available to answer questions about the EPSDT benefit. When necessary, RAE staff can help link providers to HCPF's EPSDT and Prior Authorization Request (PAR) websites. The RAE also can link providers to the State EPSDT Program Manager, Gina Robinson. When appropriate, the RAE can work with providers to request a Creative Solutions meeting that will bring together members, families, providers, RAE representatives, the State EPSDT Program Manager, DHS, and other stakeholders.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280. (EPSDT program). For the Capitated Behavioral Health Benefit, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screening to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)*	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDT policy_2RAE-Entire Policy 2. ProviderHandbook_2RAE_PG 20, 30, 40-42*misc. 3. BH_Procedures_2RAE—Slide 32 to 35-entire doc **Description of Process:** The RAE has a written policy related to the EPSDT program and its requirements. See **Policy 248L_EPSDT_2RAE** in its entirety. This policy defines eligibility for the EPSDT program as follows [Section II.A]: Any person enrolled in the Health First Colorado (Medicaid) program can get EPSDT services if they are 20 years old or younger. They are automatically enrolled and all Health First Colorado providers can offer the EPSDT services. 1. Children 18 years old and younger can get EPSDT with no co-pay for any covered service. 2. Adults 19 and 20 years old can get EPSDT, but may have a small co-pay for some services. 3. Children in Department of Social and Human Services custody can get ESPDT services with no co-pay, if they are 18 or younger. They may have some co-pays if they are 19 or 20. 4. EPSDT services may include, but not be limited to the following: providing EPSDT program information to members and families, screening (assessment), diagnosis, treatment, discretionary services (e.g., medically necessary wraparound services), referral and care coordination, and transportation and scheduling assistance.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	The RAE ensures that EPSDT screenings (assessments) are provided by primary care physicians, pediatricians, or other qualified providers whenever requested and according to the recommended periodicity schedule [**Policy 248L, Sections II.B and II.C**]. Members are informed of this right and providers are informed of their responsibilities through the RAE's website and through various training resources. The RAE's EPSDT policy specifically outlines the procedures for obtaining the results of EPSDT screenings and documenting the results [**Policy 248L, Section IV, A-P**]. The RAE's contracted behavioral health providers are responsible for documenting the results of all screenings, assessments and examinations for members receiving behavioral health services. This requirement is stated in **Policy 248L, specifically in section IV.J**: "The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered." Providers are instructed about this requirement in their onboarding training, which includes specific information about EPSDT. See BH_Procedures_2RAE—Slide 32 to 35. The BHO's Provider Manual also contains information about the EPSDT program and its documentation requirements. Please see **ProviderHandbook_2RAE_PG 20, 30, 40-42.**	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61-62* Contract Amendment 1: Exhibit B1—14.5.3	**Documents Submitted/Location Within Documents:** 1. ProviderHandbook_2RAE_PG 20, 30, 40-42 *misc. 2. 248L_EPSDT policy_2BHO-Entire Policy [Section IV.O]. **Description of Process:** The RAE's **ProviderHandbook_2RAE_PG 20, 30, 40-42** and EPSDT policy give additional clarification about offering the family or beneficiary assistance with referral assistance, appointment scheduling or transportation services [**Policy 248L_EPSDT policy_2RAE, Section II.A, last bullet point**]. The RAE has allied with community and governmental agencies such as Community Centered Boards, Single Entry Point agencies, maternal and child health programs, Head Start, WIC, SNAP, vocational rehabilitation, and other organizations providing medically necessary services that are not covered under the capitated behavioral health benefit [**248L_EPSDT policy_2RAE, Section IV.O**]. Members can obtain referrals to these programs by contacting the RAE's Access to Care line. The RAE and its behavioral health providers refer children and their families to the local Healthy Communities program for additional assistance regarding transportation issues, appointment assistance, and administrative case management. Information about the Healthy Communities program is also available on the RAE's website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options.	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDT policy_2RAE-Entire Policy **Description of Process:** The RAE has defined medical necessity for EPSDT services in its EPSDT policy, 248L_EPSDT_2RAE. Please see Section II. D (pp. 3-4) for this medical necessity definition, and see Sections IV.M through IV.O (pp. 6-7) for the UM processes related to the authorization of covered versus non-covered medically necessary services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
8. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities; clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 1: Exhibit B1—14.5.8.1	**Documents Submitted/Location Within Documents:** 1. Technical Proposal_HC—pp. 279-286. 2. HCI_ 1915b3 Waiver Services Grid, entire document **Description of Process:** HCI and its network of providers are fully capable of delivering all of the mandatory services identified in this requirement. See **Technical Proposal_HC (pp. 279-286)** for a description of these services and the **HCI_1915b3 Waiver Services Grid** for a list of locations and hours of service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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

Appendix B. Record Review Tools

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

Appendix C. Site Review Participants

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

Table C-1—HSAG Reviewers and HCI and Department Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Kathy Bartilotta	Associate Director
HCI Participants	**Title**
Alma Mejorado	Director of Provider Relations
Amie Adams	Chief Administrative Officer
Cathy Michopoulos	Interim, Director of Operations
Dawn Claycomb	Member Engagement Specialist
Deb Barnett	Director of Quality and Improvement
Erica Arnold-Miller	Director of Quality
Heather Hankins	Chief Behavioral Health Officer
Jason Brokaw	Director of Business Intelligence
Jason Chippeaux	Chief Administration Officer
Jen Hale-Coulson	Director of Care Coordination
Jeremy White	Quality Manager
Kolbie Connally	Supervisor of Integrated Healthcare
Leova Villalobos	Director of Clinical Support Services
LeAnna Pacheco	Director of Quality
Lisa Clements	Vice President of Population Health
Lynne Bakalyan	Director of Member Services
Matthew Wilkins	Director of Integrated Healthcare
Pat Perry	Care Coordination
Steve Coen	Director of Utilization Management
Department Observers	**Title**
Brooke Powers	Program Specialist—HCPF
Rahem Mulatu	Program Administrator—HCPF
Russell Kennedy	Quality Compliance Specialist—HCPF
Gina Robinson	EPSDT Program Administrator

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

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

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

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	HCI demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining a member health record in compliance with detailed documentation standards and for maintaining confidentiality and security of member health records. In addition, care compacts between individual referring and specialist providers—totaling 97 signed compacts at the time of on-site review—required sharing of clinical information between specific providers. However, no other HCI documents clearly communicated expectations that all providers *share* member records with other providers or organizations involved with a member's care.	HCI must enhance provider communications regarding the requirement that each provider furnishing services to the member shares, as appropriate, the member health record with other providers or organizations involved in the member's care.
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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, medications, social supports, community resources, and member goals.	Each accountable care coordination entity maintains its own electronic care coordination system which includes the full care coordination tool for each member. Staff members stated that HCI performs a pre-delegation assessment of each entity to ensure that each delegate's care coordination tool includes the required elements. While the pre-delegation assessment tool included, "How do you document care coordination? Please provide policy or tool," the assessment did not reflect that HCI reviews each delegate's care coordination tool to ensure collection of the minimum required elements. In addition, the PCMP Full Accountable Agreement did not detail the elements required to be included in the electronic care coordination tool.	HCI must implement mechanisms to ensure that the electronic care coordination tool used by each accountable care coordination entity includes the minimum required elements outlined in the RAE contract.

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
Contract Amendment 1: Exhibit B1—15.2.1.1, 15.2.1.3, 15.2.1.4		
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 XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
3. The RAE shall create an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE shall train Healthy Communities contractors about the Accountable Care Collaborative and the RAE's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	HCI met with four of five Healthy Communities (HC) contractors and presented information to educate HC contractors on RAE functions and activities. HCI had developed a template memorandum of understanding (MOU) and BAA intended to be signed with each of the Healthy Communities contractors and which included a description of the organizations' commitments to work together to define future activities related to onboarding and coordinating services for members. Staff members stated that HCI was actively engaged in discussions with each HC contractor and anticipated that signed agreements with HC contractors would be executed by the end of April 2019. Nevertheless, at the time of on-site review, HCI did not have an executed and implemented onboarding plan defined with each HC contractor in the region.	HCI must complete the process of developing and executing an onboarding plan with each Healthy Communities contractor in the region.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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

Overview of FY 2018–2019 Focus Topic Discussion

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

Members

Transitioning Members Into the RAE and Continuity of Care

Prior to implementation of the RAE, Beacon Health Options (Beacon) was both an organizational partner and provider of administrative management services for both the behavioral health organization (BHO) in the region and the Regional Care Collaborative Organization in Region 4; Beacon remains the administrative services partner in the Region 4 RAE. As such, Beacon's UM staff were able to identify and make lists of members actively engaged in BH treatment at the time of RAE implementation, either through inpatient census lists from providers or through BH outpatient authorizations for higher levels of BH care. All members engaged in inpatient or higher levels of care remained in treatment with established services. The BHO remained responsible for all costs for inpatient services through member discharge. For outpatient authorized care, the BHO retained responsibility for payment through June 30, 2018; and the UM staff issued authorizations for continuing care and payment through the RAE effective July 1, 2018. Through these mechanisms, the RAE needed only to communicate the change in authorization to the members' providers and to educate providers on new authorization procedures going forward. Similarly, members engaged in ongoing lower levels of BH services—not requiring authorization—were able to continue care with existing providers, and provider billing procedures remained consistent. If a member's continuity of care required a single-case agreement (SCA) with a provider, the SCA processes of the BHO were transitioned to the RAE. Members experienced no disruption in services and transition from the BHO to the RAE remained transparent for members engaged in treatment.

Prior to initiation of the RAE, Beacon invested in mass communication efforts with members through mailers, town forums, and dissemination of information through its BHO partners, the community mental health centers (CMHCs). Staff members reported that approximately 80 percent of members access BH services through the CMHCs. **HCI** used this opportunity to reach out to BH members to inform them of the new health plan name, answer questions, and ensure that benefits and services would not change. **HCI**

conducted extensive training of call center staff to ensure staff members' abilities to answer member inquiries regarding the transition to the RAE and implemented a phone texting campaign to ensure that members were aware of their RAE benefits. **HCI** also discussed the transition at member advisory meetings throughout the region. Using data from the Department and **HCI**'s BH claims database, **HCI** identified higher-risk members per the **HCI** stratification methodology and care coordinators conducted outreach calls with individual at-risk members to reassure them of continued benefits through the RAE. Staff members communicated the belief that early efforts by **HCI** to communicate with members regarding transition were effective in alleviating member anxieties regarding RAE implementation and reported that, while members were confused, they did not complain.

HCI anticipated a higher probability of problems for members due to the new attribution methodology. **HCI** encouraged providers to closely monitor their individual Medicaid patient listings in comparison to attribution lists and to identify inconsistencies. Care coordinators worked with individual members to assist in reattribution to their chosen provider, and providers queried members who came into the office for care. **HCI** also worked with the Department at the macro level to correct attribution problems. **HCI** noted that the primary mis-attribution issues were related to providers within the RAE region and not across RAE boundaries. **HCI**s objective was to ensure that nothing in the individual member's care changed and that members could continue to seek care from their preferred providers regardless of attribution. While **HCI** staff described several types of macro issues regarding the attribution methodology—primarily the geographic assignment methodology—**HCI** credited the Department for efforts in responding to the systematic attribution issues occurring within the region and stated that attribution issues have significantly improved since the time of initial implementation.

Care Coordination

In response to the integration of behavioral and physical healthcare services through the RAE, several delegated care coordination entities expanded and reorganized their internal care coordination teams. Registered nurses (RNs) and behavioral health care coordinators who may have previously operated as separate teams have been internally integrated into one team with diverse expertise. In addition, BH case managers from CMHCs and RNs in delegated PCMP entities operate as one integrated care team. Staff members stated that integration of behavioral and physical healthcare services through the RAE has improved care coordination for members and that improved communication among behavioral and physical health providers has been critical to these efforts. Staff members suggested that the Department could further facilitate improved communications between BH and PCMP providers by re-issuing to them a letter written previously from the Department to providers which reinforces the legality of BH providers sharing member information with other RAE providers involved in the member's care.

Providers

Transitioning BH Providers Into the RAE and Provider Network Contracting

Due to Beacon's previous affiliation with both the BHO and the RCCO in Region 4 and continued affiliation with the RAE, **HCI** had pre-established contracts with available BH providers across the region—all CMHCs and 600 independent provider network (IPN) providers. **HCI** amended existing BH provider contracts to apply to the RAE, thereby expediting the BH contracting process for the RAE. In addition, operational administrative processes—e.g., utilization management, billing, provider relations—were unchanged from the BHO to the RAE. For BH providers, transition to the RAE in Region 4 was relatively transparent and seamless; however, BH providers were required to contract with up to seven different RAE regions. **HCI** has also contracted with an additional 200 IPN providers in Region 2 and Region 4 and reported that 24 of those providers were still in credentialing process at the time of on-site review. Despite the available network of IPN providers, staff reported that 80 percent of BH services in the region are delivered through the CMHCs. **HCI** also held weekly webinars with PCMPs to provide updates from the State regarding the "silent" RAE contracting process, explain the new per member per month (PMPM) reimbursement, and prepare PCMPs for attribution issues. Staff members stated that PCMPs were initially "shocked" by the changing PMPM and attribution methodology. **HCI** ensured providers that they could continue to serve and be paid for care of members despite mis-attribution and encouraged providers to monitor their practice attribution lists and work with **HCI** and care coordinators to resolve attribution issues. **HCI** also conducted a "cultural change" webinar session to help PCMPs understand communications with BH providers integrated into the RAE. While members experienced relatively seamless transitions and provider contracting was largely transparent upon implementation of the RAE, providers necessarily absorbed impact of infrastructure issues—e.g., billing and payment structures—associated with the new, integrated RAE model.

HCI stated that the various methods to promote provision of BH in PCMPs' practices is complex in rural areas, where many practices are experiencing financial losses. The Department's process for reimbursing PCMPs for six routine behavioral health visits is an administrative burden for providers. In addition, members who must be transitioned from the six PCMP sessions to a BH provider—i.e., CMHC—must adjust to a totally different therapeutic environment. Practices with co-located physical and behavioral health practitioners are confused about what to bill and where to bill specific services—i.e., RAE capitation or fee for service.

Due to the vast distances, limited services, and sparse population in Region 4's rural areas, **HCI** is supportive of implementing telehealth services wherever possible to enhance the delivery of integrated care. Staff members reported implementing telehealth in some rural offices. However, many geographic areas that could benefit from telehealth lack adequate Internet infrastructure to deliver uninterrupted service. Until telecommunications companies improve infrastructure in these areas, widespread telehealth services will not be possible.

Opportunities/Challenges

HCI anticipates that members with BH needs will receive improved access to physical health services through the integrated RAE model and that integrated whole-person care will result in positive outcomes for members. BH providers have begun investing in working collaboratively with other providers, the RAE, and the Department to improve the delivery system. In addition, the sense of partnership among all entities is enhancing enthusiasm for improving care for members.

HCI also stated that community-based innovative models of service, perhaps more prevalent in rural areas where services are limited, are developing throughout the region, and described as an example the grant-based Lighthouse program in La Junta. Lighthouse BH peer specialists provide numerous services—e.g., crisis intervention, AIDS testing, health and wellness pros, bicycles, and resumé assistance—to hundreds of drop-in clients per week. Peer specialists accompany members to BH appointments and help with paperwork for members who may have language or learning difficulties (e.g., dyslexia). Nevertheless, community-based creative and integrated programs are non-traditional components of the healthcare system and are not funded through the RAE. **HCI** perceives such programs to be essential in reforming and improving healthcare and expressed the need for improved financial margins in the RAEs or additional grant-funding to support initiatives of the health neighborhood.

Among the challenges related to implementation of the RAE, **HCI** cited that providers have varying perspectives regarding the integration model, including lack of understanding as to why this shift in behavioral health has taken place in Colorado and/or why it is important to the overall population's health. The Department's policy level rationale for the RAE model has not translated to providers, nor are members able to implicitly perceive what may be better due to these changes.

HCI is concerned about the future fatigue of care coordination and case management staff, who have carried much of the burden in implementation of the RAE. In addition to the time-consuming and emotionally draining commitment to meeting Medicaid members' multiple needs, care coordinators assume a major workload in a system that does not recognize the complexity of such efforts through existing reimbursement or payment mechanisms.

HCI is additionally concerned about consist Department messaging to the RAEs that appears to place emphasis on cost savings rather than on improving member-focused care and services. Whereas the RAEs and providers have been historically member-oriented and invested in health reform for Colorado Medicaid members; the Department appears to be increasingly focused on monitoring, and portrays cost-savings as the paramount objective of the ACC. As described previously, **HCI** perceives the need for expanding some services in order for RAE objectives to be successful. To that end, **HCI** suggested that the Department improve alignment of the key performance indicators (KPIs) with major program expectations and deliver data reporting to RAEs that is actionable and timely in order to allow the RAEs and providers to impact future incentive funds. Moreover, mechanisms to improve RAEs' overall financial margins are essential for the flexibility to fund region-specific delivery system initiatives.