COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Site Review Report

for

Colorado Access

Region 5

May 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 **Colorado Access Region 5** (**COA R5**). 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. Appendix G includes compliance monitoring results for the managed care organization (MCO).

Summary of Compliance Results

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

Table 1-1 presents the scores for **COA R5** 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 RAE Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	12	11	10	1	0	1	91%
IV. Member Rights and Protections	7	7	7	0	0	0	100%
V. Member Information	19	17	16	1	0	2	94%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	7	1	0	0	88%
Totals	**46**	**43**	**40**	**3**	**0**	**3**	**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

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

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

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

Summary of Findings Resulting in Opportunities for Improvement

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

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

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

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

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

COA's MCO contractor—Denver Health Medical Plan (DHMP)—stated that it received a report from **COA** of the Department's health needs survey (HNS) results for DHMP members only twice per month. The requirement is that the MCO processes a daily data transfer from the Department containing responses to member health needs surveys; therefore, HSAG recommends that **COA** implements a process to more frequently, perhaps daily, transfer to DHMP a report of HNS results for DHMP members, thereby improving the ability of the MCO to identify members who may benefit from "timely" contact and support.

Summary of Required Actions

RAE care coordination documents and on-site interviews demonstrated that **COA** has processes in place to coordinate transitions of care from hospital and institutional stays, between settings of care, with transitions between RAEs, and with services received from agencies and community organizations. In addition, staff members stated that a **COA** care coordinator is embedded at Denver Health's emergency department, thereby enabling coordination with Denver Health's providers. However, for members not engaged in emergency services or hospital transitions of care yet receiving ongoing physical health services through Denver Health clinics and other providers, it was unclear how **COA** coordinates BH services being received through the RAE with the physical health services delivered through the MCO.

COA must more clearly outline procedures for coordinating BH services being received by individual members with those services which members receive from the Denver Health MCO.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

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

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

Summary of Findings Resulting in Opportunities for Improvement

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

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

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

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

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

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

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to in this standard.

Summary of Required Actions

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

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

Summary of Strengths and Findings as Evidence of Compliance

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

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

respite services. **COA** demonstrated tracking the utilization of these services by EPSDT-eligible members.

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

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

Summary of Findings Resulting in Opportunities for Improvement

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

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

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

While EPSDT policies outlined the complete and accurate definition of "medical necessity" related to EPSDT services, staff members explained that authorization requirements primarily apply only to inpatient and higher-level BH services (not outpatient services and referrals) and that **COA** considered the standard authorization criteria applied to these services sufficient for reviewing these services for EPSDT-eligible members. HSAG encourages **COA** to ensure that the expanded definitions of "medical necessity"—e.g., reducing "effects" of an illness, condition, or disability; a course of treatment that includes observation or no treatment at all; provides a safe environment for the child—are recognized and applied by medical reviewers making authorization decisions regarding potential EPSDT-related benefits prior to denying services.

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

Summary of Required Actions

The DHHA Healthy Communities MOU and scope of work (effective December 2018) essentially outlined an agreement for **COA** and DHHA Healthy Communities to participate in up to a two-year formal planning process that would culminate in a collaborative onboarding plan for children and families in Region 5. As such, **COA** had not yet accomplished creating an onboarding plan in partnership with DHHA Healthy Communities. **COA** must expedite the planning and implementation process with DHHA Healthy Communities to create an annual plan for onboarding of children and families.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

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

Compliance Monitoring Site Review Methodology

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

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

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

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

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

Objective of the Site Review

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

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

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefits,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all members,* the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit B1—11.3.1, 11.3.7	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Utilization Management Work Flow_RAE • Coordination and Continuity of Care Overview_RAE **DH MCO** • ACS Care Coordination Policy Draft_MCO • ACS Care Plan Policy Draft_MCO • ACS Care Coordination Program Description_MCO *Draft not included* • RN Care Coordinator ACS 16 Job Description - DBBH2653_MCO • Screenshots: ○ Care Everywhere Screenshot_MCO ○ Nurse Care Coordination InBasket Message_Redacted Screenshot_MCO ○ Nurse Care Coordinator as Primary Responsible for Coordinating Health_Redacted Screenshot_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ Care Team Activity - Care Coordinator Primary Screenshot_MCO ○ Care Team Screenshot_MCO ○ Goal and Care Team from Outside Hospital Screenshot_MCO ○ Care Team Activity - External Team Members Screenshot_MCO ○ Care Teams Screenshot_MCO ○ Care Coordination Note Screenshot_MCO ○ Care Gaps Screenshot_MCO ○ Goals Activity Non DH Goals (external) Screenshot_MCO ○ Progress Note Screenshot_MCO ○ SDOH Screenshot_MCO ○ Referrals Screenshot_MCO • Care Management Intake Standard Work April2018_MCO • CSW Goals and Interventions_MCO • Resource List on Social Work Intranet Site_MCO • Primary Care Standard Work_Referral Tracking_5.1.18_MCO • GAD-7_English_MCO • PHQ-9_English_MCO • PHQ-4 Tip Sheet v5_MCO • HIPAA Hybrid Entity Health Care Components_MCO	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07	
2. The RAE ensures that each member receiving *capitated behavioral health services* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit B1—None	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • COA_RAE Physical Health Transitions of Care Workflow_RAE • COA_RAE Behavioral Health Institutional_TOC Workflow_RAE • The Enrollment Broker mails the member letters that identify the member's PCMP as well as RAE. https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-phase-ii%E2%80%94member-messaging-resource-center#HealthFirstEnrollmentLetters **DH MCO** • Healthy Communities Standard Work_MCO • Nurse Care Coordinator as Primary Responsible for Coordinating Health_Redacted Screenshot_MCO • Care Team Activity – Care Coordinator Primary Screenshot_MCO • DHMP Medicaid Member Handbook_2018_MCO - See Pg. 4 on how to access care and set up an appointment with a PCP and Pg. 8 on choosing a PCP	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The MCO no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 1: Exhibit B1—6.8.1	**COA RAE-5** • Std III Requirement 3_Attribution_RAE **DH MCO** • DHMP Medicaid Member Handbook_2018_MCO - Pg 9	**RAE:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Colorado Access submitted evidence and described in on-site interviews having been actively engaged with the Department to resolve significant member attribution issues in Region 5. HSAG found that the extent of these issues precluded reasonable expectations for Colorado Access to follow up with members to assist each member in changing his or her attributed PCMP; therefore, HSAG scored this requirement as not applicable at this time.		
4. The RAE ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit B1—11.3.3.2	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE **DH MCO** • ACS Care Coordination Policy Draft_MCO • ACS Care Plan Policy Draft_MCO • ACS Care Coordination Program Description_MCO *Draft not included*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. Contract Amendment 1: Exhibit B1—14.3	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE **DH MCO** NA for the MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit B1—11.3.10, 11.3.5, 10.3.2, 10.3.4	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • CM DP09 CM Transitions of Care_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • Coordination and Continuity of Care Overview_RAE **DH MCO** • Inpatient Transition of Care Flowsheet with Discharge Documentation_MCO • Foster Care Clinic RNCC Standard Work_MCO	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Adult Transition of Care Flowsheet in Epic_MCO • Transitions of Care from Institutional Settings screenshot_MCO • Transitions of Care Workflow_MCO • 20170509_TOC Standard Work_Final_MCO • Care Navigator Job Description_MCO • Patient Discharge Policy_MCO • RN Care Coordinator ACS 16 - DBBH2653 Job Description_MCO	
Findings: RAE care coordination documents and on-site interviews demonstrated that Colorado Access has processes in place to coordinate transitions of care from hospital and institutional stays, between settings or care, with transitions between RAEs, and with services received from agencies and community organizations. In addition, staff members stated that a Colorado Access care coordinator is embedded at Denver Health's emergency department, thereby enabling coordination with Denver Health's providers. However, for members not engaged in emergency services or hospital transitions of care yet receiving ongoing physical health services through Denver Health clinics and other providers, it was unclear how Colorado Access coordinates BH services being received through the RAE with the physical health services delivered through the MCO.		
Required Actions: Colorado Access must more clearly outline procedures for coordinating BH services being received by individual members with the services the member receives from Denver Health MCO.		
7. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who	**COA RAE-5** • CM DP11 Health Needs Assessment Survey_RAE • COA_RAE HNA Workflow_RAE **DH MCO** • Assessment and Progress Notes_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
may benefit from timely contact and support from the member's PCMP, RAE, or MCO. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit B1—7.5.2–3	• Health Needs Survey Onboarding Assessment Workflow_MCO • HSN_CarePlanPathway- Health Needs Survey Script_MCO • Health Needs Survey Onboarding Assessment Care Plan_MCO	
8. *For the Capitated Behavioral Health Benefits:* The RAE ensures: • That each member receives an individual intake and assessment appropriate for the level of care needed. • Use of the information gathered in the member's intake and assessment to build a service plan. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit B1—14.7.1.1–3	**COA RAE-5** • Provider Manual Section 3_RAE • QM302 Quality Review of Provider Medical Records_RAE, *Page 2 #1* • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE **DH MCO** • Assessment and Progress Notes_MCO • Health Needs Survey Onboarding Assessment Workflow_MCO • HSN_CarePlanPathway- Health Needs Survey Script_MCO • Health Needs Survey Onboarding Assessment Care Plan_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. *For the Capitated Behavioral Health Benefits:* The RAE shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit B1—None	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE **DH MCO** • Care Everywhere Screenshot_MCO • Care Team Activity - External Team members Screenshot_MCO • Goal and Care Team from Outside Hospital Screenshot_MCO • Goals Activity Non DH Goals (external) Screenshot_MCO	**RAE**: ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. *For the Capitated Behavioral Health Benefits:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	**COA RAE-5** • COA Provider Manual Section 3_RAE • COA Provider Manual Section 4_RAE **DH MCO** • Legal Medical Record Policy_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 1: Exhibit B1—15.2.1.1, 15.2.1.3, 15.2.1.4	**COA RAE-5** • Std III_Req_11_Altruista screenshots_RAE **DH MCO** • Demographics in Epic Screenshot_MCO • Electronic Care Coordination Tool_MCO • Care Team Activity - Care Coordinator Primary Screenshot _MCO • Care Team Screenshot_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The RAE ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable.	**COA RAE-5** • PRI 100 Protecting Member PHI_RAE • PRI 101 Clinical Staff Use and Disclosure of Member PHI_RAE • PRI 103 Authorizations to Disclose Member PHI_RAE	**RAE:** ☒ 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)(6) Contract: 20.B Contract Amendment 1: Exhibit B1—11.3.7.11, 15.2.1.2.2	• PRI 104 Member Rights and Requests Regarding PHI_RAE • PRI 105 Personal Representatives and Member PHI_RAE • PRI 200 Sanctions Policy_RAE • HIP 204 Security of EPHI_RAE **DH MCO** • Legal Medical Record Policy_MCO • HIPAA Hybrid Entity Health Care Components Policy_MCO • MU-Epic-Denver Health System-CO-Denver-CAPP-2018 Summary of Findings_MCO	

RAE Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	91%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit B1—7.3.7.1–2	**COA RAE-5** • CS212 Member Rights and Responsibilities_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights and ensure that employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit B1—7.3.7.3	**COA RAE-5** • CS212 Member Rights and Responsibilities_RAE • Provider Manual Section 2_RAE • See link on COA website: https://www.coaccess.com/members/services/rights/	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	**COA RAE-5** • CS212 Member Rights and Responsibilities_RAE • ADM208 Member Materials_RAE • COA website: https://www.coaccess.com/members/services/rights/	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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		
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 health plan, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit B1—7.3.7.2.7	**COA RAE-5** • ADM203 Member Grievances_RAE • Provider Manual Section 2_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract Amendment 1: 21.U	**COA RAE-5** • ADM205 Nondiscrimination_RAE • ADM206 Culturally Sensitive Services for Diverse Populations_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • ADM230 Member Disability Rights Request and Resolution_RAE • MKT201 Printed Marketing/Informational and Corporate Branding Materials_RAE • COA Provider Manual Section 2_RAE • See COA website: https://www.coaccess.com/nondiscrimination/ • http://www.coaccess.com/documents/Notice-of-Privacy-Practices.pdf	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: 20.A Exhibit A—2.c and 3.a	**COA RAE-5** • PRI 100 Protecting Member PHI_RAE • PRI 101 Clinical Staff Use and Disclosure of Member PHI_RAE • PRI 103 Authorizations to Disclose Member PHI_RAE • PRI 104 Member Rights and Requests Regarding PHI_RAE • PRI 105 Personal Representatives and Member PHI_RAE • PRI 200 Sanctions Policy_RAE • HIP 204 Security of EPHI_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The RAE maintains written policies and procedures and provide 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 institutionwide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated.	**COA RAE-5** • CCS303 Advance Directives_RAE • Provider Manual Section 2_RAE • **Web Site:** https://www.coaccess.com/members/services/	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.11.3–7		

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 1: Exhibit B1—7.2.5, 7.2.7.9	**COA RAE-5** • ADM206 Culturally Sensitive Services for Diverse Populations_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • MKT DP 03 Accessibility Standards - 508/ADA Compliance_RAE • Minutes from the Member Advisory Council_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit B1—7.3.6.1.8	**COA RAE-5** • See COA website content and link to HCPF Member Handbook: https://www.coaccess.com/members/care/ • New Member Packet_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-	**COA RAE-5** • N/A	**R5 RAE:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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		
Findings: The Department has not provided a list of these definitions to the health plans, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the health plans to be aware of this requirement and to consistently use definitions from the Department when available.		
4. The RAE makes written information available in prevalent non-English languages in their service areas 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.	**COA RAE-5** • ADM205 Nondiscrimination_RAE • ADM206 Culturally Sensitive Services for Diverse Populations_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • MKT201 Printed Marketing/Informational and Corporate Branding Materials_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Include taglines in large print (18-point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit B1—7.2.7.3–9, 7.3.13.3		
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	**COA RAE-5** • MKT203 Website Design Maintenance and Oversight_RAE • MKT DP03 Accessibility Standards 508/ADA Compliance_RAE • See COA website: https://www.coaccess.com/	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	**COA RAE-5** • See COA website for link, section on Physical Health: https://www.coaccess.com/members/care/	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The RAE makes interpretation services (for all non-English languages) available free of charge, notify members that oral interpretation is available for any language and written translation is available in prevalent languages, and inform 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 inform how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit B1—7.2.6.2–4	**COA RAE-5** • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM208 Member Materials_RAE • CS DP28 Nextalk for TTY_RAE • CS DP29 Interpreting Services_RAE • See: https://www.coaccess.com/members/services/ • Voiance MSA with BAA_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit B1—7.2.6.1, 7.2.6.5	**COA RAE-5** • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • CS DP29 Interpreting Services_RAE • See COA website and language options at top of page: www.coaccess.com	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit B1—None	**COA RAE-5** • New Member Packet_RAE • BRD for New Member Mailing Lists_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 1: Exhibit B1—None	**COA RAE-5** • ADM328 Significant Changes in Members Rights, Benefits or Processes_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 1: Exhibit B1—7.3.8.1	**COA RAE-5** • ADM208 Member Materials_RAE • New Member Packet_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	**COA RAE-5** • ADM300 Provider Terminations_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The RAE develops and maintains a customized and comprehensive website which includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit B1—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	**COA RAE-5** • RAE Website_Std_V_Requirement 13_RAE	**R5 RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: COA's website included clear and concise information about the required topics. For trainings, COA include both provider trainings and videos designed to assist members in understanding benefits offered and who to contact for additional information. The section that addressed filing and processing appeals, however, contained outdated information.		
Required Actions: COA must ensure that information on its website includes updated and correct information.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 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	**COA RAE-5** • See COA Provider Directory at: https://coadirectory.info/search-member	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. Provider directories are made available on the RAE's website in machine-readable files and formats. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	**COA RAE-5** • See COA provider directory at: https://coadirectory.info/search-member	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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. • 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.	**COA RAE-5** • New Member packet_RAE • RAE Materials_Std_V_Req 16_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 1: Exhibit B1—7.3.6.1		
17. The RAE annually mails each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit B1—7.3.8.1	**COA RAE-5** • Annual DOI mailing_RAE	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ 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 auxiliary aids and services upon request at no cost.	**COA RAE-5** • New member packet_RAE • ADM207 Effective Communication with LEP and SI-SI Persons_RAE • ADM230 Member Disability Rights Request_RAE • See language on web, "For Our Members": www.coaccess.com	**R5 RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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		
19. The RAE makes available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit B1—None	**COA RAE-5** • PNS218 Physician Incentive Plans_RAE	**R5 RAE:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Colorado Access staff members reported that the RAE has no physician incentive plans that meet the definition of a physician incentive plan as it is defined in the RAE contract with the Department.		

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

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. Contract Amendment 1: Exhibit B1—7.3.12.1	**COA RAE-5** • CCS315 EPSDT_RAE • See COA website: https://www.coaccess.com/members/care/epsdt/ **DH MCO** • DHMP EPSDT Member_webpage_2018_MCO • DHMP Medicaid Member Handbook_2018_MCO • DHMP EPSDT Member Newsletters 2018_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information, including: • Employing Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. • Advising network providers of EPSDT support services available through other entities including, but not limited to, local public health departments and Healthy Communities. Contract Amendment 1: Exhibit B1—7.6.2.3, 12.8.3.4; 12.9.3.4	**COA RAE-5** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE **DH MCO** • DHMP EPSDT Provider Newsletter 2018_MCO • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • DHMP_Provider Manual_EPSDT Section_MCO • HealthyCommunitiesPediatricCareCoordination_MCO • EPSDT_Provider_Cornerstone Training_12.21.18_MCO • EPSDT_2018_NEO Roster_MCO • DHMP EPSDT Provider Webpage_2018_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE creates 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 trains Healthy Communities contractors about the Accountable Care Collaborative and the Contractor's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	**COA RAE-5** • DHHA Healthy Communities MOU • TCHD Health Communities MOU_RAE **DH MCO** • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • DHMP Medicaid Member Handbook_2018_MCO • DHHA Healthy Communities - COA RAE R5 MOA Addendum 2 Annual Onboarding Plan_MCO (Draft 10-31-18) • DHHA Healthy Communities - COA RAE R5 MOA Addendum 1 Statement of Work_MCO (Draft 10-31-18)	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Colorado Access submitted a Denver Health and Hospital Authority (DHHA) memorandum of understanding (MOU) and scope of work (SOW) (effective December 2018) which documented the commitment of Colorado Access and DHHA Healthy Communities to work together in a two-year formal planning process to develop and implement an onboarding plan for Medicaid children and families. Staff stated that the organizations are meeting bimonthly to accomplish the planning process. At the time of on-site review, Colorado Access had not created an annual onboarding plan in collaboration with DHHA Healthy Communities contractors. Colorado Access continues to refer members and providers to Healthy Communities for assistance in accessing services.		
Required Actions: Colorado Access must expedite the planning and implementation process with the Denver County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.		

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	**COA RAE-5** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE • EPSDT UMCM training report_RAE • EPSDT in Action R5_RAE **DH MCO** • DHMP_Provider Manual_EPSDT Section_MCO • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHMP EPSDT Provider Webpage_2018_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	**COA RAE-5** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE • See COA website: https://www.coaccess.com/members/care/epsdt/ **DH MCO** N/A	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
6. *For the Capitated Behavioral Health Benefits,* 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	**COA RAE-5** • CCS315 EPSDT_RAE **DH MCO** • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHMP Medicaid Member Handbook_2018_MCO • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • ABA Services Follow_Up_Example 1_MCO • ABA Services Follow_Up_Example 2_MCO • EPSDT and ABA Referral Tracking Std Work_MCO • Early Intervention Referral _ Example 1_MCO • Early Intervention Referral_Example 2_MCO • EI Referral Tracking Std Work_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefits,* 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. Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	**COA RAE-5** • CCS315 EPSDT_RAE • EPSDT in Action R5_RAE **DH MCO** • MCD_CHP_UM01 Utlization Review Determinations Including Approvals and Actions_MCO • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • DHMP_Provider Manual_EPSDT Section_MCO • DHMP Medicaid Member Handbook_2018_MCO	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities; clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 1: Exhibit B1—14.5.8.1	**COA RAE-5** • CCS315 EPSDT_RAE • EPSDT in Action R5_RAE **DH MCO** N/A	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Appendix B. Record Review Tools

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

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **COA R5**.

Table C-1—HSAG Reviewers and COA R5 and Department Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Katherine Bartilotta	Associate Director
COA R5 Participants	**Title**
Aaron Bove	Care Manager
Aleasha Sykes	Care Coordinator, Manager
Amanda Berger	Supervisor of Care Management
Ana Brown-Cohen	Health Program Manager
Andrea Rodriguez	Compliance Contractor
Bethany Himes	Vice President of Provider Engagement
Bryce Anderson	Supervisor of Care Management
Cassidy Smith	Senior Program Director
Chase Gray	Senior Director of Health Services
Danielle Schroeder	Care Management, Manager
Daniel Obarksi	Director, Payment Reform
Elizabeth Strammiello	Chief Compliance Officer
Eric Bretillo	Director of Marketing and Communication
Gretchen McGinnis	Senior Vice President of Healthcare Systems
Jamie Zayac	Supervisor of Care Management
Janet Milliman	Director of CHP+ and Program Deliverables and Operations
Jason Beard	Web Manager, Strategic Communications
Jenny Nate	Director, Behavioral Health Provider and Network Support
John Wilson	Care Manager
Joseph Anderson	Director of Care Management
Josie Koth	Programs Coordinator
Kelly Marshall	Director of Community and External Relations
Krista Beckwith	Senior Director of Population Health and Quality
Lauren Showers	Care Manager
Lindsay Cowee	Director of Utilization Management and Pharmacy

COA R5 Participants	Title
Marty Janssen	Senior Program Director
Michelle Tomsche	Director of Claims Operations and Research
Mika Gans	Manager of Quality Improvement
Rachel Baker	Interim Compliance Officer
Rebecca Fox	Care Manager
Reyna Garcia	Senior Director of Customer Service
Robert Bremer	Vice President of Network Strategy
Shelby Kiernan	Director of Practice Transformation
Stephanie Becker-Aro	Care Manager
Toni Johnson	Care Manager
Department Observers	**Title**
Amanuel Melles	Program Administrator
Chris Tzortzis	Program Administrator
Jeff Appleman	Program Specialist
Ben Harris	Program Specialist
Russ Kennedy	Quality and Compliance Specialist
Gina Robinson	EPSDT Program Administrator

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

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for COA Region 5

Standard III—Coordination and Continuity of Care—MCO Only		
Requirement	**Findings**	**Required Action**
2. The MCO ensures that each member receiving *capitated physical health services* 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 M1—None	While DHMP assigned each newly enrolled Medicaid member to a primary care clinic within DH's system, DHMP did not inform any member of his or her assigned clinic provider until the member called DH central scheduling for an appointment, at which time the member could choose to change the assigned provider. In addition, DH demonstrated that the member may have several care managers from throughout the DH system—depending on the member's needs identified through the course of treatment—but provided no evidence that the member is informed of how to contact his or her lead/primary care coordinator.	DHMP must implement mechanisms to provide information to members on how to contact the person or entity primarily responsible for coordinating his or her healthcare services, including the PCMP and, as applicable, his or her lead care manager.
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—MCO Only		
Requirement	**Findings**	**Required Action**
5. The MCO implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit M1—11.3.10, 11.3.5, 10.3.2, 10.3.4, 14.5.1.3	DH documentation demonstrated coordinating services for members transitioning between settings of care (including discharge planning), directing providers to use the Department's prior authorization request to obtain services provided by FFS Medicaid, referring high-level behavioral health services to Colorado Access utilization management (UM), and providing members with referrals to community organizations and social support providers. Nevertheless, DH documents and staff interviews failed to demonstrate ongoing active care coordination with the Colorado Access concerning BH services being provided through the RAE or with community organizations and agencies providing social support services to members.	DHMP must enhance and implement procedures to actively coordinate with services that the member receives from the RAE as well as with services the member receives from external community organizations and social support providers.
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—RAE Only		
Requirement	**Findings**	**Required Action**
6. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit B1—11.3.10, 11.3.5, 10.3.2, 10.3.4	RAE care coordination documents and on-site interviews demonstrated that Colorado Access has processes in place to coordinate transitions of care from hospital and institutional stays, between settings or care, with transitions between RAEs, and with services received from agencies and community organizations. In addition, staff members stated that a Colorado Access care coordinator is embedded at Denver Health's emergency department, thereby enabling coordination with Denver Health's providers. However, for members not engaged in emergency services or hospital transitions of care yet receiving ongoing physical health services through Denver Health clinics and other providers, it was unclear how Colorado Access coordinates BH services being received through the RAE with the physical health services delivered through the MCO.	Colorado Access must more clearly outline procedures for coordinating BH services being received by individual members with the services the member receives from Denver Health MCO.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard III—Coordination and Continuity of Care—RAE Only		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care—MCO Only		
Requirement	**Findings**	**Required Action**
7. *For the Capitated Physical Health Benefits:* The MCO ensures: • That each member receives an individual intake and assessment appropriate for the level of care needed. • Use of the information gathered in the member's intake and assessment to build a service plan. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit M1—14.5.1.1–3	DH demonstrated that each member receives an intake assessment and care plan upon presentation to a DH clinic. While DHMP staff members described that DHMP is working on a plan to outsource this activity for all Medicaid members, DHMP had not implemented a mechanism— beyond the member's presentation for a clinic-based appointment—to ensure that *all* members receive an intake assessment and related care plan.	DHMP must implement a mechanism to provide an individual intake assessment and related service plan for each member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—MCO Only		
Requirement	**Findings**	**Required Action**
4. The MCO makes written information available in prevalent non-English languages in their service areas 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	DHMP developed its own member handbook, member welcome packet, and annual member letter as required. The materials were easily understood and readily accessible, and the font sizes were as required. DHMP; however, did not, at the time of the interview, have a process to have its materials member-tested. DHMP staff members reported that a process had been developed but not yet implemented.	DHMP must ensure that all member materials critical to obtaining services are member-tested.

Standard V—Member Information—MCO Only		
Requirement	**Findings**	**Required Action**
customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit M1—7.2.7.3–9, 7.3.13.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—MCO Only		
Requirement	**Findings**	**Required Action**
11. For any MCO member handbook or supplement to the member handbook provided to members, the MCO ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The Contractor 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 M1—7.3.8.1	DHMP's member handbook included the member information requirements at 438.10(g); however, the information provided about the grievance and appeal system was outdated and did not reflect the changes pursuant to the revised Medicaid managed care regulations released May 2016.	DHMP must revise the member handbook to ensure compliance with the managed care regulations released May 2016.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—RAE Only		
Requirement	**Findings**	**Required Action**
13. The RAE develops and maintains a customized and comprehensive website which 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	Colorado Access' website included clear and concise information about required website elements; however, the section that addressed filing and processing of appeals contained outdated information.	COA must ensure that information on its website includes updated and correct information regarding appeals procedures.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information—MCO Only		
Requirement	**Findings**	**Required Action**
16. The Contractor develops electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • Contractor's single toll-free customer service phone number. • Contractor's email address. • Contractor's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity, prepaid inpatient health plan (PIHP), and MCO. • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the Contractor. • Medicaid benefits, including State Plan benefits and those in the *Limited Managed Care Capitation Initiative*. • Any restrictions on the member's freedom of choice among network providers. • The Contractor's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services	DHMP's written and electronic materials included all the requirements to assist newly enrolled members in understanding DHMP's program. None, however, described the basic features of the RAE's (Colorado Access') managed care functions as a primary care case management (PCCM) entity, prepaid inpatient health plan (PIHP), and MCO; or DHMP's relationship to Colorado Access. In additional the "Provider Directory Tips" (the introductory section of the provider directory) was outdated and referred to the behavioral health organizations (BHOs) as where members would receive behavioral health care.	DHMP must include in its written enrollment materials and its website, a description of the basic features of the RAE's managed care functions as a PCCM entity, PIHP, and MCO as well as DHMP**'s** relationship to Colorado Access for the administration of the Limited Managed Care Capitation Initiative. In addition, DHMP must revise any materials that do not accurately refer to Colorado's current care delivery system.

Standard V—Member Information—MCO Only		
Requirement	**Findings**	**Required Action**
that the Contractor does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the Contractor, including member satisfaction. Contract Amendment 1: Exhibit M1—7.3.6.1		
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—Both RAE and MCO		
Requirement	**Findings**	**Required Action**
3. The RAE creates 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 trains Healthy Communities contractors about the Accountable Care Collaborative and the Contractor'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	Colorado Access submitted a Denver Health and Hospital Authority (DHHA) memorandum of understanding (MOU) and scope of work (effective December 2018) which essentially outlined an agreement for Colorado Access and DHHA Healthy Communities to participate in up to a two-year formal planning process that would culminate in a collaborative onboarding plan for children and families in Region 5. As such, at the time of on-site review, Colorado Access had not yet accomplished creating an onboarding plan in partnership with DHHA Healthy Communities. In addition, at the time of on-site review, the MCO—DHMP—had not created an annual onboarding plan in collaboration with the DHHA Healthy Communities contractor.	Colorado Access must expedite the planning and implementation process with the Denver County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families. DHMP must expedite the planning and implementation process with the Denver County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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

Overview of FY 2018–2019 Focus Topic Discussion

For the FY 2018–2019 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE*. Focus topic interviews were designed to emphasize the member-related and provider-related components of transition and integration, including successes and challenges experienced in this inaugural year of RAE operations. HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the 2018–2019 RAE Aggregate Report to determine and document statewide trends related to the ACC objective of integrating behavioral and physical healthcare for members. This section of the report contains the interview guide and a summary of the focus topic discussion for **COA R5**.

Members

Transitioning Members Into the RAE and Continuity of Care

Prior to RAE implementation, **COA** was the Regional Care Collaborative Organization (RCCO) and the behavioral health organization (BHO) for Region 5. By working with the Department and BHO claims database, **COA** was able to use a data-driven methodology to identify Region 5 members receiving BH services, identify potentially high-risk members for continuity of care, and provide advanced messaging to these members to introduce **COA** as the new RAE organization through which they would receive their BH services. Member letters provided assurances that if the member was receiving services in Denver County nothing would change. For members in authorized placement, the **COA** BH care managers remained involved with the member through transition to the RAE. In addition, **COA** identified BH providers serving Region 5 members, and if those providers were not already contracted with **COA**, prioritized them for contracting with the RAE.

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

COA anticipated some shift in member population between RAE regions, particularly for members residing in the border areas of Region 5; however, the initial attribution data identified significant shifts

in member population, both in and out of the region, and between the Denver Health MCO and the RAE. Department letters to members, which communicated the member's assigned PCMP, caused much consternation for members. For the first 30 to 90 days following RAE implementation, general inquiries to **COA** customer services increased significantly. **COA** conducted training for its customer service and care management teams concerning the new attribution methodology, designed member messaging scripts, and instructed staff on when and how to escalate concerns to another level of investigation. If members were receiving services from a BH provider not yet contracted with the RAE, **COA** applied continuity-of-care rules so that the member could continue care with a non-contracted provider for a period of time.

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

Due to the overlap of the RCCO and previous BHO in Region 5, **COA** reported that most members receiving BH services were transitioned into the RAE without disruption to ongoing care.

Care Coordination

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

Providers

Transitioning BH Providers Into the RAE and Provider Network Contracting

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

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

At the time of on-site review, **COA** had 29 integrated physical health and behavioral health practices in Region 5. While **COA** is open to facilitating transition of any BH provider interested in working within an integrated PCMP practice, **COA** also had previously worked with Mental Health Center of Denver (MHCD)—the CMHC in Region 5—regarding co-locating, offering BH therapists for hire, or providing other supports for PCMP integrated practices. Staff members stated that MHCD had experience with "match-making" between PCMPs and BH therapists. **COA** stated that the FFS reimbursement for up to six BH visits is too low to support the financial viability of integrated practices. Staff members described **COA**'s enhanced payment model to support PCMP practices that have employed BH providers by reimbursing higher rates for 20 BH codes. Twelve PCMP sites are currently participating in the enhanced payment model, and **COA** intends to expand access to enhanced payment methodologies to additional integrated practice sites.

COA also discussed the tele-behavioral health program offered by **COA** to all PCMPs to offer peer-to-peer consultations or virtual therapy to members in primary care offices. **COA** hires BH clinicians to provide these services free of charge to PCMPs. At the time of on-site review, **COA** had 27 PCMPs participating in this service. **COA** offered direct member therapy for up to six in-office therapy sessions, as allowed by the RAE's FFS BH code. Peer-to-peer consultation can also be applied to other BH modalities, such as medication management. Staff members stated that BH medication changes for members have been the most significant outcome of this service. In 2018, **COA** tele-behavioral health

clinicians provided 300 direct patient encounters and 498 peer-to-peer consultations. Not all provider offices are able to hire an in-office BH provider or expand office services to accommodate an on-site BH therapist; therefore, tele-health services enabled more widespread delivery of BH services throughout the RAE network. **COA** plans to expand the offering of tele-health services to all BH providers and will involve the CMHCs in expansion strategies. COA practice transformation teams and tele-health trainers work with individual practices to help them understand how to integrate various BH modalities into their practices.

Opportunities/Challenges

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

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

COA identified that other general RAE implementation challenges included:

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

office location aligned with the RAE. **COA** worked with providers and the enrollment broker to correct this problem. In addition, because Denver Health specialty providers may provide services to either Denver Health MCO members or RAE members, Denver Health providers must be particularly diligent in confirming whether a member is attributed to Denver Health MCO or to the RAE in order to bill services correctly. **COA** and Denver Health conducted provider training pre-and post-RAE implementation to ensure that PCMPs checked eligibility of each member and informed specialists of whether the member was an MCO or FFS member. Major shifts in member attribution between the RAE and the MCO further aggravated this situation. The Department extended the 90-day MCO opt-out period for members. Nevertheless, not only might some members receive multiple member enrollment packets from both Denver Health and the Department, but providers' confusion in billing FFS or capitated services results in Denver Health not receiving an accurate monthly capitation payment. At the time of on-site review, **COA** stated that significant attribution issues continue and that collaborative efforts to resolve these issues are also continuing between RAEs across the State and the Department as well as between **COA** and the Denver Health MCO.

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

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

COLORADO
Department of Health Care Policy & Financing

Appendix G:
Fiscal Year 2018–2019 Site Review Report
for
Colorado Access
Region 5 Managed Care Initiative

May 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

Appendix G: Table of Contents

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). In addition, the **Colorado Access Region 5** (**COA R5**) RAE contract incorporates into the RAE a limited managed care initiative for capitated physical health services (managed care organization [MCO]), applicable to a designated service area within the Region. 42 CFR requires PCCMs, PIHPs, and MCOs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCMs, PIHPs, and MCOs 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 the **COA R5** limited managed care initiative—**Denver Health Medical Plan** (**DHMP**). 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. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 MCO site review activities. Appendix G-1 contains the compliance monitoring tool for the review of the MCO standards.

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 MCO scores for **DHMP** 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 G-1—Compliance Monitoring Tool.

Table 1-1—Summary of MCO Scores for the 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	10	7	3	0	1	70%
IV. Member Rights and Protections	7	7	7	0	0	0	100%
V. Member Information	19	17	14	3	0	2	82%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**44**	**41**	**34**	**7**	**0**	**3**	**83%**

*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

DHMP uses the care coordination resources of the Denver Health and Hospital Authority (Denver Health) delivery system to coordinate care for Medicaid members. Whereas Denver Health (DH) is a large and diverse system of services, members receive most needed services from DH and its partner organizations. The Department assigns each newly enrolled Medicaid member to a PCMP, which may include DH. Once a member is assigned to DH as an ongoing source of care, **DHMP** assigns the member to a medical home—i.e., one of the DH system primary care clinics—based on the residential geographic location of the member. Each clinic has a multidisciplinary team of clinicians and care managers assigned by DH's Ambulatory Care Services division to provide on-site services to members who present at the clinic. The *ACS Care Coordination* policy described that care management staff are available at each of nine family health centers, three urgent care centers, and 17 school-based health centers to assist members with chronic, complex, and catastrophic disorders requiring coordination of care across multiple provider disciplines or settings. Clinic-based care-coordination teams consisted of registered nurse (RN) care managers, social worker (SW) care managers, and patient navigators. In addition, DH had a centralized staff of RN care managers to assist members transitioning from inpatient settings, which was confirmed through DH's *Patient Discharge* policy and other transition of care documents.

The *ACS Care Coordination* policy and *ACS Care Plan* policy addressed all requirements of RAE care coordination requirements, including: providing care coordination at the point of care; addressing both short and long-term medical, behavioral, and social needs; respecting member preferences and cultural characteristics; supporting communication among practitioners and the member's care team; identifying a lead coordinator; and addressing potential gaps in meeting the member's diverse needs. DH has adopted predictive risk modeling using clinical risk group software and recent member utilization data to categorize members into four tiers of risk—Tier 1 (lower risk) to Tier 4 (higher risk)—to guide care planning and interventions. DH demonstrated using a variety of assessment tools and member interview scripts to determine member needs and develop related care plan interventions, including a comprehensive assessment and care plan for members with complex needs. All members accessing ambulatory care in the DH system—regardless of risk stratification tier level—received an intake assessment and had a plan of care documented in the Epic electronic record system (Epic). Depending on the various types of member needs, each member could have multiple care managers within his or her care team; and, each team member conducted assessments and care plan updates associated with his or her level of expertise. All components of the member's care plan were documented and correlated in Epic and could be communicated among all DH staff and providers as well as among DH provider partners with access to Epic. DH demonstrated—through examples of documentation in Epic—deliberate provider interventions and coordination with other aspects of the delivery system, including between settings of care, with providers external to the DH system, authorization requests to the Department, and member referrals to community support organizations. The Epic electronic health record collected all care coordination information required in the RAE contract with the Department. Member medical records were also documented and maintained in Epic, and Denver Health and

Hospital Authority (DHHA) policies and procedures regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance described mechanisms for maintaining security of personal health information (PHI) among DH's healthcare components and addressed prohibited disclosure of PHI.

DHMP staff members stated that **DHMP** had the capability to maintain oversight of all DH care manager activities for Medicaid members through its medical director and four medical management staff members. **DHMP**'s UM department reviewed the Department's health needs survey (HNS) to determine continuity of care needs for new enrollees and ensure continuing care during transition into the MCO. Staff members indicated that **DHMP** is considering integrating the results of the Department's HNS into the Epic EHR when the volume of completed HNSs increases. While ACS care teams conducted an intake assessment of members presenting at a clinic site, **DHMP** staff members stated that **DHMP** was also considering implementing an intake assessment of all new Medicaid enrollees using an outside vendor.

Summary of Findings Resulting in Opportunities for Improvement

While **DHMP** utilized the care coordination process provided through DH, no evidence indicated that **DHMP** had formally adopted DHHA policies and procedures applicable to **DHMP**'s managed care requirements. HSAG recommends that **DHMP** develop a mechanism to represent that it has reviewed and formally adopted applicable DHHA policies as **DHMP**'s policies and to ensure that those policies meet all **DHMP** managed care requirements.

DH documents, specifically ACS care coordination policies and other related documents describing care management activities, were written at a high level and lacked specific procedures or assigned accountabilities for performing care coordination functions. HSAG recommends that DHHA policies and procedures and other related documents—i.e., various standard of work documents—outline specific procedures and accountabilities for the care coordination processes described. HSAG also recommends that DH consider defining overall program organizational charts or flow diagrams to correlate all disparate activities and responsibilities within the systemwide care coordination program.

While **DHMP** had a process to review and use the Department's HNS, **DHMP** stated that it received a report from Colorado Access of HNS results for **DHMP** members only twice per month. The requirement is that the MCO processes a daily data transfer from the Department containing responses to member health needs surveys; therefore, HSAG recommends that **DHMP** work with Colorado Access to improve the frequency of receiving a report from Colorado Access of HNS results for **DHMP** members, thereby improving the ability of the MCO to identify members who may benefit from "timely" contact and support.

Summary of Required Actions

While **DHMP** assigned each newly enrolled Medicaid member to a primary care clinic within DH's system, **DHMP** did not inform any member of his or her assigned clinic provider until the member called DH central scheduling for an appointment, at which time the member could choose to change the assigned provider. In addition, DH demonstrated that the member may have several care managers from throughout the DH system—depending on the member's needs identified through the course of treatment—but provided no evidence that the member is informed of how to contact his or her lead/primary care coordinator. **DHMP** must implement mechanisms to provide information to members on how to contact the person or entity primarily responsible for coordinating his or her healthcare services, including the PCMP and, as applicable, his or her lead care manager.

DH documentation demonstrated coordinating services for members transitioning between settings of care (including discharge planning), directing providers to use the Department's prior authorization request to obtain services provided by FFS Medicaid, referring high-level behavioral health services to Colorado Access utilization management (UM) program, and providing members with referrals to community organizations and social support providers. Nevertheless, DH documents and staff interviews failed to demonstrate ongoing active care coordination with Colorado Access concerning BH services which members were receiving through the RAE or with community organizations and agencies providing social support services to members. **DHMP** must enhance and implement procedures to actively coordinate with the services the member receives from the RAE as well as with services the member receives from external community organizations and social support providers.

DH demonstrated that each member receives an intake assessment and care plan upon presentation to a DH clinic. However, at the time of on-site review, **DHMP** had not implemented a mechanism—beyond the member's presentation for a clinic-based appointment—to attempt to ensure that every member received an intake assessment and related care plan. **DHMP** must implement a mechanism to provide an individual intake assessment and related service plan for each member.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

DHMP, COA's contractor to administer the Limited Managed Care Capitation Initiative submitted its *Member Rights and Responsibilities* policy that included all of the rights afforded members pursuant to 42 CFR 438.100. **DHMP**'s policy listed applicable laws and regulations and articulated the MCO's commitment to comply with all other federal and State regulations pertaining to member rights. In addition, the MCO submitted specific policies to demonstrate compliance with regulations related to advance directives and privacy and confidentiality rights guaranteed under HIPAA. HIPAA policies addressed access to protected health information (PHI), use, disclosure, minimum necessary requirements, encryption, transmission, electronic storage, paper storage, disposal, and handling suspected breaches.

DHMP provided evidence of member and provider communications and processes for training to ensure that members and providers understand member rights and that members may exercise those rights without fear of retaliation.

Summary of Findings Resulting in Opportunities for Improvement

DHMP's policy that addressed advance directives stated that **DHMP** has adopted the DHHA policy regarding advance directives. The DHHA policy was very specific to in-patient needs and processes regarding advance directives. HSAG recommended that **DHMP** consider reviewing its policy to determine if processes and requirements for its contracted providers (generally single case agreements) should be added to the policy; for example, how contracted providers are informed of their responsibilities related to advance directives. Examples may be distribution of information related to advance directives or ensuring that medical records contain either the advance directives or information stating that the member has not provided an advance director.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

HSAG found that **DHMP** had processes for testing member materials for sixth grade readability and to ensure that specific documents available electronically on the **DHMP** website are machine readable and comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. HSAG tested the materials and website during the on-site review and found that **DHMP** was compliant with these requirements.

DHMP had a variety of materials designed to assist members in understanding the requirements and benefit of the managed care plan and State plan benefits. **DHMP** had developed a member welcome packet for annual mailing and continues to distribute the **DHMP** Medicaid member handbook. **DHMP**'s Medicaid page of its website had the required information and included member orientation videos. **DHMP** also used member newsletters to inform members about preventive care and condition-specific self-care tips. **DHMP** provided a rotation of topics for its member and provider newsletters. New member and annual mailings were printed in English and Spanish. All member materials reviewed by HSAG included taglines in English and Spanish. Materials were written in 12-point font with taglines in English and Spanish and in 18-point font. Member-specific communications submitted for review (such as grievance and appeal letters) included taglines in English and Spanish and in 18-point font. **DHMP** provided evidence of effective processes for providing language line assistance for translation and in-

person translations (including sign language) when needed. **DHMP** staff members described provision of materials in other formats when needed, which included Braille.

DHMP's website included all required information through direct description of the information required or through links to pages within the website or to the State's website (e.g., for the Health First Colorado [HFC] member handbook and information regarding the State laws related to advance directives).

DHMP's provider directory included all required content. The introduction to the provider directory, "Provider Directory Tips," included a table of each **DHMP** provider site and a checklist of 24 Americans with Disabilities Act (ADA) accessibility features or auxiliary aides available at each site. The tips document also stated that the health plan "ensures that all services are provided in a culturally competent manner and are accessible to all members. This includes members with limited English and reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds."

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

DHMP, COA's contractor to administer the Limited Managed Care Capitation Initiative, developed its own member handbook, member welcome packet, and annual member letter as required. The materials were easily understood and readily accessible, and font sizes were as required. At the time of on-site review, **DHMP** did not have in place a process to have its materials member-tested. **DHMP** staff members reported that a process had been developed but had not yet been implemented. **DHMP** must ensure that all member materials critical to obtaining services are member-tested.

DHMP's member handbook included the member information requirements at 438.10(g); however, the information provided about the grievance and appeal system was outdated and did not reflect the changes pursuant to the revised Medicaid managed care regulations released May 2016. **DHMP** must revise the member handbook to ensure compliance with the managed care regulations released May 2016.

DHMP's written and electronic materials included all the requirements to assist newly enrolled members in understanding **DHMP**'s program. None, however, described the basic features of the RAE's (Colorado Access') managed care functions as a PCCM entity, PIHP, or MCO, or **DHMP**'s relationship to Colorado Access. In addition, the "Provider Directory Tips" (the introductory section of the provider directory) were outdated and referred to the behavioral health organizations (BHOs) for where the members will receive behavioral health care. **DHMP** must include in its written enrollment materials and its website, a description of the basic features of the RAE's managed care functions as a PCCM entity, PIHP, and MCO as well as **DHMP**'s relationship to Colorado Access for the administration of

the Limited Managed Care Capitation Initiative. In addition, **DHMP** must revise any materials that do not accurately refer to Colorado's current care delivery system.

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

Summary of Strengths and Findings as Evidence of Compliance

DHMP informed members and parents through the **DHMP** website, **DHMP** member handbook, and member newsletters of the full range of EPSDT benefits, the periodicity schedule, scheduling and transportation assistance, Healthy Communities, and how to obtain more information. **DHMP** provided comprehensive training and information to providers regarding the EPSDT program and benefits and Healthy Communities through the provider manual, provider website, DHHA's *Pediatric and Adolescent Preventive Healthcare Guidelines,* and the Department's EPSDT webinar training for providers. **DHMP** demonstrated having conducted provider training and having distributed provider newsletter EPSDT updates within the past six months. **DHMP**'s *EPSDT Program* policy addressed all required components of physical health EPSDT screenings with expanded definitions of what is included in specific screenings as well as requirements to provide diagnostic and treatment services for conditions discovered by screenings, referrals for wraparound services, and making use of State agencies and programs specified in the **DHMP** contact with the Department. The policy stated that **DHMP** quality improvement staff monitored provider compliance with the EPSDT schedule; staff members demonstrated a comprehensive tool for provider-specific tracking and reporting of compliance with numerous EPSDT screening and immunization requirements. Staff members stated that such comprehensive tracking was enabled through the Epic electronic health record. DH's ACS care manager standard work documents outlined step by step expectations for follow-up of referrals for EPSDT-related services. The EPSDT policy and UM policy accurately described medical necessity criteria for EPSDT. The UM medical director stated that **DHMP** makes every effort to approve authorization of service requests related to EPSDT and refers non-covered service denials to either the Department (for wrap-around services) or Colorado Access (for BH services). **DHMP** continues to refer members and providers to Healthy Communities for assistance in accessing services, including Healthy Communities' follow-up with members who received postcard reminders regarding EPSDT services to assist with scheduling appointments. **DHMP** demonstrated significant attentiveness to EPSDT requirements throughout the DH system.

Summary of Findings Resulting in Opportunities for Improvement

The **DHMP** website informed members of basic and expanded EPSDT benefits available through members' PCPs, including well-child checks by age category and a link to the Bright Futures periodicity schedule. The **DHMP** member handbook described in detail EPSDT benefits and wrap-around services and informed members regarding the Bright Futures periodicity schedule but did not list *when* services

are needed nor refer the member to the periodicity schedule on the **DHMP** website. HSAG recommends that member communications refer the member to the **DHMP** website for the schedule of EPSDT screening services.

DHMP demonstrated that it provided EPSDT training during new employee orientations and in December 2018. However, the EPSDT policy stated that DH providers and staff are trained *annually* on EPSDT benefits. HSAG recommends that **DHMP** modify the policy to specify that providers are trained or updated "every six months," as stated in MCO contract requirements.

The EPSDT policy characterized "resolving barriers" to provision of EPSDT services as: providers placing a referral to other providers, **DHMP** UM, or the Department; or contacting Healthy Communities. HSAG finds that these processes do not represent how **DHMP** assists providers with resolving barriers and problems related to EPSDT. During on-site interviews, staff members described examples of how customer service and care management staff assist providers with resolving barriers related to EPSDT benefits. HSAG recommends that **DHMP** include in its EPSDT policy and procedures and related provider communications a description of how customer service and care management staff can assist providers in resolving barriers or problems related to EPSDT benefits.

HSAG noted that the EPSDT policy contained outdated information referring to the BHO and Exhibit I-1 of the **DHMP** Medicaid contract. HSAG recommends that **DHMP** correct or remove outdated information from its policy.

While the EPSDT policy contained statements that **DHMP** will provide assistance with transportation or scheduling appointments and will make use of the State health agencies specified in contract requirements, the policy did not include procedures describing by whom or how these services are provided. HSAG recommends that **DHMP** strengthen language in the policy to more definitively address procedures associated with implementation of policy statements.

HSAG noted that the **DHMP** Medicaid member handbook UM section states, "For definition of medically necessary for EPSDT services please see EPSDT section;" however, the EPSDT section of the member handbook did not include the EPSDT medical necessity criteria. HSAG recommends that **DHMP** correct this oversight in the member handbook.

Summary of Required Actions

DHMP submitted a DHHA Healthy Communities memorandum of understanding (MOU) and scope of work (SOW) (effective December 2018) which documented the commitment of Colorado Access and DHHA Healthy Communities to work together in a two-year formal planning process to develop and implement an onboarding plan for Medicaid children and families. **DHMP** was not included as a participant or signatory in either the MOU or SOW. At the time of on-site review, **DHMP** had not created an annual onboarding plan in collaboration with the DHHA Healthy Communities contractor. **DHMP** must engage in and expedite the planning and implementation process with the Denver County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights and Protections; Standard V—Member Information; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated for the limited managed care initiative (MCO) through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE 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* for the MCO. 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 and MCO 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, and member and provider informational materials. While the RAE and MCO managed care requirements were reviewed simultaneously on-site, HSAG delineated results for each product line into individual separate reports. However, required corrective actions for the MCO are the responsibility of the RAE and are incorporated into Appendix D of the RAE Region 5 report.

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 MCO'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 MCO 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 MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the MCO's services related to the standard areas reviewed.

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DHMP** until it completed each of the required actions from the FY 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2017–2018, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Related to member information, **DHMP** was required to revise its Medicaid member handbook to include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination) and to clarify that members must exhaust the **DHMP** appeals process before requesting a State fair hearing.

Related to the grievance system, **DHMP** was required to:

- Update grievance and appeal policies and procedures, including all appendices and attachments, with language in compliance with the Medicaid managed care rule and all associated State and program contract requirements; ensure that all staff members are aware of and have mechanisms in place for appropriately managing appeals and grievances; and ensure that policies and procedures are updated timely in accordance with all federal, State, and program rule changes.
- Update policies related to the appeals process to include correct language and time frame within which a member may file an appeal.
- Ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.
- Include in appeals policies and the notice of appeal resolution letter accurate information about when a member or a designated representative may request a State fair hearing.
- Ensure that all providers and subcontractors are provided with information about the grievance, appeal, and fair hearing systems upon entering into contracts with **DHMP**.

Related to provider participation and program integrity, **DHMP** was required to:

- Have mechanisms in place for: promptly reporting all overpayments identified or recovered due to potential fraud; screening all provider claims for potential fraud, waste, or abuse; and notifying the Department about changes in a network provider's eligibility to participate in the Medicaid program.
- Have documented procedures for notifying the Department of written disclosure of any prohibited affiliation, written disclosure of ownership and control, and identification of any excess payments made to the contractor.
- Have mechanisms for ensuring that network providers report to **DHMP** receipt of an overpayment, return the overpayment to **DHMP**, and notify **DHMP** of the reason for the overpayment.; and report annually to the Department on recoveries of overpayments.

Related to subcontracts and delegation, **DHMP** was required to:

- Subject all potential subcontractors to a pre-delegation assessment to ensure that the organization is qualified and capable of performing the tasks to be delegated, ensure ongoing and formal monitoring of every subcontractor, and require corrective actions to mitigate any identified deficiencies or areas of improvement.
- Have a written agreement with every subcontractor that includes the delegated activities and related reporting responsibilities and that specifies remedies for instances in which the subcontractor fails to meet performance standards.
- Have a written agreement with every subcontractor that requires the subcontractor to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.
- Have a written agreement with every subcontractor that includes the auditing provisions outlined in 42 CFR 438.230(c)(3).

Summary of Corrective Action/Document Review

DHMP submitted a proposed CAP in February 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **DHMP**. **DHMP** submitted documents as evidence of completion of its proposed interventions in October 2018. HSAG and the Department reviewed documents submitted and responded to **DHMP** with approved completion of two of 13 required actions and required resubmission of additional documents as evidence of completion for 11 of 13 required actions. The Department established a due date of March 2019 for resubmission of documents.

Summary of Continued Required Actions

As of the date of this 2018–2019 compliance report, 11 of 13 2017–2018 required actions were continued pending review of CAP documents resubmitted by **DHMP**. Continued required actions included: one required action related to member information; three required actions related to the grievance system; three required actions related to provider participation and program integrity; and four required actions related to subcontracts and delegation. HSAG will review **DHMP**'s CAP submission with the Department and work with the health plan to ensure full implementation of all corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Physical Health Benefits,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all members*, the MCO'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 MCO ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)*	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Utilization Management Work Flow_RAE • Coordination and Continuity of Care Overview_RAE **DH MCO** • ACS Care Coordination Policy Draft_MCO • ACS Care Plan Policy Draft_MCO • ACS Care Coordination Program Description_MCO *Draft not included* • RN Care Coordinator ACS 16 Job Description - DBBH2653_MCO • Screenshots: ○ Care Everywhere Screenshot_MCO ○ Nurse Care Coordination InBasket Message_Redacted Screenshot_MCO ○ Nurse Care Coordinator as Primary Responsible for Coordinating Health_Redacted Screenshot_MCO	**MCO:** ☒ 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 M1—11.3.1, 11.3.7	○ Care Team Activity - Care Coordinator Primary Screenshot_MCO ○ Care Team Screenshot_MCO ○ Goal and Care Team from Outside Hospital Screenshot_MCO ○ Care Team Activity - External Team Members Screenshot_MCO ○ Care Teams Screenshot_MCO ○ Care Coordination Note Screenshot_MCO ○ Care Gaps Screenshot_MCO ○ Goals Activity Non DH Goals (external) Screenshot_MCO ○ Progress Note Screenshot_MCO ○ SDOH Screenshot_MCO ○ Referrals Screenshot_MCO • Care Management Intake Standard Work April2018_MCO • CSW Goals and Interventions_MCO • Resource List on Social Work Intranet Site_MCO • Primary Care Standard Work_Referral Tracking_5.1.18_MCO • GAD-7_English_MCO • PHQ-9_English_MCO • PHQ-4 Tip Sheet v5_MCO • HIPAA Hybrid Entity Health Care Components_MCO	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07	
2. The MCO ensures that each member receiving *capitated physical health services* 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 M1—None	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • COA_RAE Physical Health Transitions of Care Workflow_RAE • COA_RAE Behavioral Health Institutional_TOC Workflow_RAE • The Enrollment Broker mails the member letters that identify the member's PCMP as well as RAE. https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-phase-ii%E2%80%94member-messaging-resource-center#HealthFirstEnrollmentLetters **DH MCO** • Healthy Communities Standard Work_MCO • Nurse Care Coordinator as Primary Responsible for Coordinating Health_Redacted Screenshot_MCO • Care Team Activity – Care Coordinator Primary Screenshot_MCO • DHMP Medicaid Member Handbook_2018_MCO - See Pg. 4 on how to access care and set up an appointment with a PCP and Pg. 8 on choosing a PCP	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The Department assigns each Medicaid member, on enrollment, to a PCMP, which may include Denver Health. Once a member is assigned to Denver Health (DH) as an ongoing source of care, Denver Health Medical Plan (DHMP) assigns the member to medical home—i.e., one of the DH system primary care clinics—based on the residential geographic location of the member. Each clinic has a care team consisting of primary care clinicians and, as needed, care managers or navigators to provide services to the member. DHMP does not inform the member of the assigned clinic provider until the member calls DH central scheduling for an appointment, at which time the member may change the assigned clinic provider. In addition, DH demonstrated that the member may have several care managers from throughout the DH system, depending on the member's needs throughout the course of treatment, but provided no evidence that the member is informed of how to contact his or her lead/primary care coordinator.		
Required Actions: DHMP must implement mechanisms to provide information to members on how to contact the person or entity primarily responsible for coordinating his or her healthcare services, including the PCMP and, as applicable, his or her lead care manager.		
3. Members enrolled in the MCO have 90 days in which to opt out. Any member who does not opt out remains enrolled until the member's next open enrollment period, at which time the member shall receive an open enrollment notice. Subsequent enrollment will be for 12 months, and a member may not disenroll from the RAE's *Managed Care Capitation Initiative*. Contract Amendment 1: Exhibit M1—6.7	**COA RAE-5** • Std III Requirement 3_Attribution_RAE **DH MCO** • DHMP Medicaid Member Handbook_2018_MCO - Pg 9	**MCO:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: The DHMP Medicaid Member Handbook informed members that they may opt out of attribution to the DH system within 90 days of enrollment, and how to do so. Staff members also discussed that DHMP has designated staff to regularly review attribution reports from the Department and has been working with Colorado Access and the Department to correct attribution issues. Staff members reported that attribution issues have resulted in major shifts—sometimes several thousand—of members between the MCO and RAE and have been ongoing since inception of the RAE contract. The Department has extended the opt-out period for members pending resolution of Department attribution issues; therefore, HSAG scored this requirement as *Not Applicable* at this time.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The MCO 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 M1—11.3.3.2	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE **DH MCO** • ACS Care Coordination Policy Draft_MCO • ACS Care Plan Policy Draft_MCO • ACS Care Coordination Program Description_MCO *Draft not included*	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The MCO implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit M1—11.3.10, 11.3.5, 10.3.2,10.3.4, 14.5.1.3	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • CM DP09 CM Transitions of Care_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • Coordination and Continuity of Care Overview_RAE **DH MCO** • Inpatient Transition of Care Flowsheet with Discharge Documentation_MCO • Foster Care Clinic RNCC Standard Work_MCO • Adult Transition of Care Flowsheet in Epic_MCO	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Transitions of Care from Institutional Settings screenshot_MCO • Transitions of Care Workflow_MCO • 20170509_TOC Standard Work_Final_MCO • Care Navigator Job Description_MCO • Patient Discharge Policy_MCO • RN Care Coordinator ACS 16 - DBBH2653 Job Description_MCO	
Findings: DHMP uses care management services provided to members throughout the Denver Health (DH) delivery system. DH procedures and other documentation demonstrated coordinating services for members transitioning between settings of care (including discharge planning), directing providers to use the Department's prior authorization request to obtain services provided by FFS Medicaid, referring high-level behavioral health services to Colorado Access utilization management (UM), and providing members with referrals to community organizations and social support providers. Many services to meet member needs could be provided within the diverse services of DH, and the Epic electronic health record (EHR) served as the source for coordinating with DH system providers and DH external clinical partners. Nevertheless, DH documents and staff interviews failed to demonstrate ongoing active care coordination with the Colorado Access concerning BH services being provided through the RAE or with community organizations and agencies providing social support services to members.		
Required Actions: DHMP must clarify and/or implement procedures to actively coordinate with services that the member receives from the RAE as well as with services the member receives from external community organizations and social support providers.		
6. The MCO uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The MCO: • 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	**COA RAE-5** • CM DP11 Health Needs Assessment Survey_RAE • COA_RAE HNA Workflow_RAE **DH MCO** • Assessment and Progress Notes_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
may benefit from timely contact and support from the member's PCMP, RAE, or MCO. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit M1—7.5.2–3	• Health Needs Survey Onboarding Assessment Workflow_MCO • HSN_CarePlanPathway- Health Needs Survey Script_MCO • Health Needs Survey Onboarding Assessment Care Plan_MCO	
7. *For the Capitated Physical Health Benefits:* The MCO ensures: • That each member receives an individual intake and assessment appropriate for the level of care needed. • Use of the information gathered in the member's intake and assessment to build a service plan. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit M1—14.5.1.1–3	**COA RAE-5** • Provider Manual Section 3_RAE • QM302 Quality Review of Provider Medical Records_RAE, *Page 2 #1* • CCS305 Colorado Access Care Coordination_RAE • CCS306 Delivering Continuity and Transition of Care for Members_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE **DH MCO** • Assessment and Progress Notes_MCO • Health Needs Survey Onboarding Assessment Workflow_MCO • HSN_CarePlanPathway- Health Needs Survey Script_MCO • Health Needs Survey Onboarding Assessment Care Plan_MCO	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DH demonstrated that each member receives an intake assessment and care plan upon presentation to a DH clinic. While DHMP staff members described that DHMP is working on a plan to outsource this activity for all Medicaid members, DHMP had not implemented a mechanism—beyond the member's presentation for a clinic-based appointment—to ensure that *all* members receive an intake assessment and related care plan.		
Required Actions: DHMP must implement a mechanism to provide an individual intake assessment and related service plan for each member.		
8. *For the Capitated Physical Health Benefits:* The MCO shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit M1—None	**COA RAE-5** • CCS305 Colorado Access Care Coordination_RAE • COA_RAE Physical Health Transitions of Care Work Flow_RAE • COA_RAE Behavioral Health Work Flow_All Care Settings_RAE **DH MCO** • Care Everywhere Screenshot_MCO • Care Team Activity - External Team members Screenshot_MCO • Goal and Care Team from Outside Hospital Screenshot_MCO • Goals Activity Non DH Goals (external) Screenshot_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. *For the Capitated Physical Health Benefits:* The MCO ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards.	**COA RAE-5** • COA Provider Manual Section 3_RAE • COA Provider Manual Section 4_RAE	**MCO:** ☒ 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)(5) Contract Amendment 1: Exhibit M1—None	**DH MCO** • Legal Medical Record Policy_MCO	
10. The MCO possess 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. Contract Amendment 1: Exhibit M1—15.2.1.1, 15.2.1.3, 15.2.1.4	**COA RAE-5** • Std III_Req_11_Altruista screenshots_RAE **DH MCO** • Demographics in Epic Screenshot_MCO • Electronic Care Coordination Tool_MCO • Care Team Activity - Care Coordinator Primary Screenshot _MCO • Care Team Screenshot_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The MCO 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.	**COA RAE-5** • PRI 100 Protecting Member PHI_RAE • PRI 101 Clinical Staff Use and Disclosure of Member PHI_RAE	**MCO:** ☒ 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)(6) Contract: 20.B Contract Amendment 1: Exhibit M1—11.3.7.11, 15.2.1.2.2	• PRI 103 Authorizations to Disclose Member PHI_RAE • PRI 104 Member Rights and Requests Regarding PHI_RAE • PRI 105 Personal Representatives and Member PHI_RAE • PRI 200 Sanctions Policy_RAE • HIP 204 Security of EPHI_RAE **DH MCO** • Legal Medical Record Policy_MCO • HIPAA Hybrid Entity Health Care Components Policy_MCO • MU-Epic-Denver Health System-CO-Denver-CAPP-2018 Summary of Findings_MCO	

MCO Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	70%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO has written policies regarding the member rights specified in 42 CFR 438.100. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit M1—7.3.7.1–2	**DH MCO** • Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07_MCO This policy shows member rights listed out	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The MCO complies with any applicable federal and State laws that pertain to member rights and ensure that employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit M1—None	**DH MCO** • Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07_MCO • Creation, Review and Readability of Member Materials- MCD_CHP_GVT06v.10_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The MCO's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment.	**DH MCO** • Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07_MCO - Policy shows each bullet point for member rights • DHMP Medicaid Member Handbook_2018_MCO - Pg. 14 shows member rights as listed in the bullets	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit M1—7.3.7.2.1–6; 7.3.7.4		
4. The MCO 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 health plan, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit M1—7.3.7.2.7	**DH MCO** • Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07_MCO - Policy shows this specific member right • DHMP Medicaid Member Handbook_2018_MCO - Pg. 14 shows member rights as listed in the bullets	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The MCO 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	**DH MCO** • Member Rights and Responsibilities Policy - MCD_CHP_GVT02v07_MCO - This policy shows these specific federal and State laws	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract Amendment 1: Exhibit M1—5.2.4		
6. For medical records and any other health and enrollment information that identifies a particular member, the MCO 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	**DH MCO** • 2017 Managed Care HIPAA Privacy Program Manual - FINAL_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The MCO maintains written policies and procedures and provide written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCO. Advance directives policies and procedures include: • A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience.	**DH MCO** • MCD_CHP_GVT12 v. 09 - Advance Medical Directives_MCO - below documents are referenced in this policy and meet audit requirements ○ Advance Directives- MDPOA- CPR Directives- Living Wills- MOST.pd_MCO ○ P-1.506 Attachment A- Advance Directives Summary Table_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • 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.	○ P-1.506 Attachment B- Medical Durable Power of Attorney Form F50-255_MCO ○ P-1.506 Attachment C- Colorado Directive to Withhold CPR Form F60-496_MCO ○ P-1.506 Attachment D- Living Will Declarations Form F50-198_MCO ○ P-1.506 Attachment E- MOST FORM Colorado Medical Orders for Scope of Treatment F60-849_MCO ○ Proxy Decision-Maker_MCO ○ Religious Accommodation Request Form_MCO ○ Religious Accommodations and Conscience Objections Relative to Provision of Care_MCO	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives. • Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit M1—7.3.11.3–7		

MCO 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 MCO provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The Contractor 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 M1—7.2.5, 7.2.7.9	**DH MCO** • DHMP Readability Log 2018_MCO • DHMP Readability Log 2019_MCO • Medicaid Provider Directory Tips_MCO • DHMP Medicaid Member Handbook_2018_MCO • Creation, Review and Readability of Member Materials- MCD_CHP_GVT06v.10_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The MCO 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 M1—7.3.6.1.7	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO • Medicaid Choice Orientation Video_MCO • Medicaid Quick Ref Guide 2018 – English_MCO • Medicaid Quick Ref Guide Annual Mailing 2019_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the MCO 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,	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO • Pharmacy Denial Letter_MCO	**DH MCO:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 1: Exhibit M1—3.6		
Findings: The Department has not provided a list of these definitions to the health plans, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the health plans to be aware of this requirement and to consistently use definitions from the Department when such are available.		
4. The MCO makes written information available in prevalent non-English languages in their service areas 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	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO • Medicaid Provider Directory Tips_MCO • Appeal Resolution Adverse to Member_MCO • Appeal Resolution In Favor of Member_MCO • Medicaid Choice Adverse Benefit Determination Letter_MCO • Medicaid Quick Ref Guide 2018 – English_MCO	**DH MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18-point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit M1—7.2.7.3–9, 7.3.13.3	• Medicaid Quick Ref Guide Annual Mailing 2019_MCO	
Findings: Denver Health Medical Plan (DHMP), COA's contractor to administer the limited MCO capitated initiative, developed its own member handbook, member welcome packet, and annual member letter as required. The materials were easily understood and readily accessible, and the font sizes were as required. DHMP; however, did not, at the time of the interview, have a process to have its materials member-tested. DHMP staff members reported that a process had been developed but not yet implemented.		
Required Actions: DHMP must ensure that all member materials critical to obtaining services are member-tested.		
5. *If the MCO 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.	**DH MCO** • Medicaid Choice Website Accessibility_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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 M1—7.3.14.1		
6. The MCO makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: Exhibit M1—14.2.1.7.2.1–2	**DH MCO** • Medicaid Choice.CHP Formulary_1Q2019_508_MCO • Medicaid Choice Formulary Location_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The MCO makes interpretation services (for all non-English languages) available free of charge, notify members that oral interpretation is available for any language and written translation is available in prevalent languages, and inform about how to access those services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The MCO notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and inform how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit M1—7.2.6.2-4	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO • Medicaid Provider Directory Tips_MCO • Language Line Services Agreement_Amendment_MCO • Language Line Services American Master Agreement_MCO • DHHA Non Discrimination for Auxillary Languages_MCO • Evaluating Members Non-English Language Needs for Language Translation Services_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor 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 M1—7.2.6.1, 7.2.6.5	**DH MCO** • Language Line Services Agreement_Amendment_MCO • Language Line Services American Master Agreement_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The MCO 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 M1—None	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO • Medicaid Quick Ref Guide 2018 - English_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The MCO 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 M1—None	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO - Pg. 9 • Member Newsletter Content Requirements-MCD_CHP_GVT05v.11_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. For any MCO member handbook or supplement to the member handbook provided to members, the MCO ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The Contractor ensures that its member handbook or supplement references a link to the Health First Colorado member handbook.	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO - Pg. 28	**DH MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10 Contract Amendment 1: Exhibit M1—7.3.8.1		
Findings: DHMP's member handbook included the member information requirements at 438.10(g); however, the information provided about the grievance and appeal system was outdated and did not reflect the changes pursuant to the revised Medicaid managed care regulations released May 2016.		
Required Actions: DHMP must revise the member handbook to ensure compliance with the managed care regulations released May 2016.		
12. The MCO 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 M1—7.3.10.1	**DH MCO** • CRE06 v. 05 - Provider Termination Policy_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor develops and maintains a customized and comprehensive website which includes: • Contractor'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.	**DH MCO** • DHMP Website_MCO • Website Provider Directory_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit M1—7.3.9.1.1-5; 7.3.9.1.9-11; 7.3.9.2		
14. The MCO 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 days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit M1—7.3.9.1.6	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO - Pg. 5 references how to find a provider using the directory • Provider Directory Example_MCO • Required Provider Directory Information-MCD_CHP_GVT01v.03_MCO • Website Pharmacy Directory_MCO • Creation, Review and Readability of Member Materials- MCD_CHP_GVT06v.10_MCO • Medicaid Provider Directory Tips_MCO • Jan 2019 Pharmacy Directory_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. Provider directories are made available on the MCO's websites in machine-readable files and formats. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit M1—7.3.9.1.8	**DH MCO** • Website Provider Directory_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor develops electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • Contractor's single toll-free customer service phone number. • Contractor's email address. • Contractor's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity, prepaid inpatient health plan (PIHP), and MCO. • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the Contractor. • Medicaid benefits, including State Plan benefits and those in the *Limited Managed Care Capitation Initiative*. • Any restrictions on the member's freedom of choice among network providers. • The Contractor's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the Contractor does not cover because of moral or religious objections.	**DH MCO** • Creation, Review and Readability of Member Materials- MCD_CHP_GVT06v.10_MCO • Medicaid Quick Ref Guide 2018 – English_MCO • Medicaid Quick Ref Guide Annual Mailing 2019_MCO	**DH MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• To the extent possible, quality and performance indicators for the Contractor, including member satisfaction. Contract Amendment 1: Exhibit M1—7.3.6.1		
Findings: DHMP's written and electronic materials included all the requirements to assist newly enrolled members in understanding DHMP's program. None, however, described the basic features of the RAE's (Colorado Access') managed care functions as a primary care case management (PCCM) entity, prepaid inpatient health plan (PIHP), and MCO; or DHMP's relationship to Colorado Access. In additional the "Provider Directory Tips" (the introductory section of the provider directory) was outdated and referred to the behavioral health organizations (BHOs) as where members would receive behavioral health care.		
Required Actions: DHMP must include in its written enrollment materials and its website a description of the basic features of the RAE's (Colorado Access') managed care functions as a PCCM entity, PIHP, and MCO; and DHMP's relationship to Colorado Access for the administration of the Limited Managed Care Capitation Initiative. In addition, DHMP must revise any materials that do not accurately refer to Colorado's current care delivery system.		
17. The Contractor annually mails each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit M1—7.3.8.1	**DH MCO** • Medicaid Quick Ref Guide Annual Mailing 2019_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The MCO 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	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO • Req. 18 Website Information_MCO • Clarity 2019 Reissue_MCO	**DH MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit M1—None		
19. The MCO makes available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit M1—None	**DH MCO** • DHMP Medicaid Member Handbook_2018_MCO - DHMC has no provider incentives	**DH MCO:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: DHMP staff members reported that the MCO has no physician incentive plans that meet the definition of a physician incentive plan as it is defined in the RAE contract with the Department.		

MCO Results for Standard V—Member Information							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	82%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO 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. • The MCO provides information to members and parents about: – The periodicity table. – Scheduling and transportation to EPSDT appointments. – The full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid. Contract Amendment 1: Exhibit M1—Scope of Work—7.3.12.1 Exhibit M1—Covered Services—1.1.14.1	**COA RAE-5** • CCS315 EPSDT_RAE • See COA website: https://www.coaccess.com/members/care/epsdt/ **DH MCO** • DHMP EPSDT Member_webpage_2018_MCO • DHMP Medicaid Member Handbook_2018_MCO • DHMP EPSDT Member Newsletters 2018_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The MCO makes network providers aware of the Colorado Medicaid EPSDT program information, including: • Employing Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. • Advising network providers of EPSDT support services available through other entities including,	**COA RAE-5** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE **DH MCO** • DHMP EPSDT Provider Newsletter 2018_MCO • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • DHMP_Provider Manual_EPSDT Section_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
but not limited to, local public health departments and Healthy Communities. Contract Amendment 1: Exhibit M1—12.8.3.4, 12.9.3.4, 14.2.2.5.2	• HealthyCommunitiesPediatricCareCoordination_MCO • EPSDT_Provider_Cornerstone Training_12.21.18_MCO • EPSDT_2018_NEO Roster_MCO • DHMP EPSDT Provider Webpage_2018_MCO	
3. The MCO creates an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The MCO trains Healthy Communities contractors about the Accountable Care Collaborative and the Contractor's unique interventions and processes. • The MCO 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 M1—7.6.2.2–4	**COA RAE-5** • DHHA Healthy Communities MOU • TCHD Health Communities MOU_RAE **DH MCO** • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • DHMP Medicaid Member Handbook_2018_MCO • DHHA Healthy Communities - COA RAE R5 MOA Addendum 2 Annual Onboarding Plan_MCO (Draft 10-31-18) • DHHA Healthy Communities - COA RAE R5 MOA Addendum 1 Statement of Work_MCO (Draft 10-31-18)	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DHMP submitted a DHHA Healthy Communities memorandum of understanding (MOU) and scope of work (SOW) (effective December 2018) which documented the commitment of Colorado Access and DHHA Healthy Communities to work together in a two-year formal planning process to develop and implement an onboarding plan for Medicaid children and families. DHMP was not reflected as a participant or signatory on either the MOU or SOW. At the time of on-site review, DHMP had not created an annual onboarding plan in collaboration with the DHHA Healthy Communities contractor. DHMP continues to refer members and providers to Healthy Communities for assistance in accessing services, including follow-up with members who receive DH postcard reminders regarding EPSDT services, to assist with scheduling appointments.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DHMP must expedite the planning and implementation process with the Denver County Healthy Communities contractor to create an annual plan for onboarding of Medicaid children and families.		
4. The MCO assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit M1—12.8.6.3	**COA RAE-5** • CCS315 EPSDT_RAE • Provider Manual Section 10_RAE • EPSDT UMCM training report_RAE • EPSDT in Action R5_RAE **DH MCO** • DHMP_Provider Manual_EPSDT Section_MCO • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHMP EPSDT Provider Webpage_2018_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For children under the age of 21, the MCO provides or arranges for the provision of all medically necessary *Capitated Physical 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 Physical Health Benefit*, the MCO: • Has written policies and procedures for providing EPSDT services to members ages 20 and under.	**COA RAE-5** • N/A **DH MCO** • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHMP_Provider Manual_EPSDT Section_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. Screenings include: – Comprehensive unclothed physical exam. – Detailed health and developmental history. – Assessment of vision, hearing, mouth, oral cavity, and teeth (with referral to a dentist beginning at age 1). – Developmental screening. – Appropriate immunizations. – Lead toxicity screening. – Age-specific screenings and laboratory tests. – Health education and anticipatory guidance. • Ensures screenings are performed by a provider qualified to furnish primary medical 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 physical illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)*	• DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 1: Exhibit M1—Statement of Work—7.7.5.2 Exhibit M1—Covered Services—1.1.14.1 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
6. *For the Capitated Physical Health Benefits,* the MCO: • 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 M1—7.7.5.2	**COA RAE-5** • CCS315 EPSDT_RAE **DH MCO** • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHMP Medicaid Member Handbook_2018_MCO • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • ABA Services Follow_Up_Example 1_MCO • ABA Services Follow_Up_Example 2_MCO • EPSDT and ABA Referral Tracking Std Work_MCO • Early Intervention Referral _ Example 1_MCO • Early Intervention Referral_Example 2_MCO • EI Referral Tracking Std Work_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Physical Health Benefits*, the MCO 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. Contract Amendment 1: Exhibit M1—7.7.5.3.7 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	**COA RAE-5** • CCS315 EPSDT_RAE • EPSDT in Action R5_RAE **DH MCO** • MCD_CHP_UM01 Utlization Review Determinations Including Approvals and Actions_MCO • MCD_QI16 v. 08 - Early and Periodic Screening Diagnostic and Treatment Benefit (EPSDT) Program_MCO • DHHA_Pediatric and Adolescent Preventive Healthcare Guidelines_MCO • DHMP_Provider Manual_EPSDT Section_MCO • DHMP Medicaid Member Handbook_2018_MCO	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

MCO Results for Standard XI—EPSDT Services							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	86%