COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Compliance Review Report

for

Colorado Access

Region 5

February 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (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.

Colorado Access (COA) showed strong understanding of the federal regulations reviewed, with only two elements scored below *Met*, one each in Standard VIII and Standard XI. While the overall score was 96 percent, COA scored lower overall for both of the standards with *Partially Met* findings compared with the standard scores from the prior review.

Table 1-1 presents the scores for COA for each of the standards. Findings for all requirements are summarized in Section 2—Assessment and Findings. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* are included in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%~
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%~
VIII. Credentialing and Recredentialing	33	32	31	1	0	1	97%v
XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	7	7	6	1	0	0	86%v
Totals	**56**	**55**	**53**	**2**	**0**	**1**	**96%**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	72	72	72	0	0	100%~
Recredentialing	54	54	54	0	0	100%~
Totals	**126**	**126**	**126**	**0**	**0**	**100%~**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

COA presented comprehensive evidence of its care coordination program structure through policies, procedures, and detailed interview descriptions. The program leveraged a multidisciplinary team of experienced professionals to address the unique needs of each member. Member identification for care coordination occurred through various channels, including utilization management, population health assessments, admission/discharge data, health risk screenings, outreach initiatives, and referrals from both family members and self-referrals. Once a member identified with a need and was enrolled into the care coordination program, COA reported the member received ongoing support, resources, and communications from their assigned care coordinator and care manager.

Although staff members could not report on specific numbers for how many members receive care coordination services for RAE 5, staff members reported it serviced an estimate of 3,000 members across all lines of business. Member outreach is attempted multiple times through phone calls and mail. Care coordinator contact information can be found within the letter the member receives. All contacts with members are documented and tracked in the HealthEdge GuidingCare workflow management system.

The policy, Transitions of Care, described how members were transitioned between different healthcare settings. Staff reported that members are supported by a team of care coordinators and care managers to ensure a smooth transition from a multitude of different types of healthcare settings. COA reported that this process ensures continuity of care through transitions such as inpatient care settings, emergency department (ED) visits, between managed care plans, and child to adult transitions. As for ensuring services are not duplicated, COA shares information between providers, care coordinators, and other care team members. Within the Care Coordination policy, COA described how sharing assessment and evaluation results assist with care plan design, goal setting, both short- and long-term interventions, and actively preventing duplication of services.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

COA staff members reported that it provided members with information pertaining to their rights and responsibilities through the member handbook and through the website at any time and members could receive a copy upon request, at no charge. The member handbook listed the rights and responsibilities that are required in accordance with the federal regulations at 42 CFR 438.100. In addition, during the interview, COA noted that staff members and providers were trained on member rights to ensure that staff members and providers could assist members with their rights and responsibilities. COA provided a member rights policy to which COA staff members and providers regularly have access.

The Non-Discrimination policy described how COA does not discriminate against individuals—including those with disabilities—in all areas of public life, and provides equal access to its services, benefits, and programs. The policy also noted a member can submit a complaint if they felt discriminated against, and how to do so. COA staff members confirmed during the review that any reported member rights issue would be investigated and sufficiently resolved.

COA submitted multiple documents that described how COA ensured the confidentiality of protected health information (PHI) when creating, maintaining, and sharing information. COA outlined measures to ensure the necessary safeguards were in place regarding sharing member PHI, including secure information exchange (i.e., encrypted emails), and use of authorizations to disclose PHI.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

COA demonstrated compliance with National Committee for Quality Assurance (NCQA) standards through robust credentialing and recredentialing policies and procedures for both practitioners and organizations. COA provided detailed descriptions of its credentialing department, associated software systems, credentialing committee composition, and the thorough application review process. Throughout the interview, COA demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures.

COA's credentialing process included a thorough file verification, with varying levels of review based on file complexity. After receiving an application, credentialing staff members verified information within the files. COA described the evaluation process for files, depending on the level of review required. Clean files were approved by the medical director on a daily basis, while more complex files required in-depth review and discussion by the credentialing committee.

COA's credentialing committee is comprised of diverse member qualifications and specialties, including physicians, counselors, and a nurse midwife. COA's credentialing policies extensively detailed the process for conducting credentialing and recredentialing in a nondiscriminatory manner. Further, all credentialing committee members complete nondiscrimination attestations on an annual basis. COA also described a process to conduct audits of files that may suggest potential discriminatory practice or if a practitioner complains about alleged discrimination.

COA reported that it averaged a 21-day turnaround time for review and decision-making of initial credentialing files in calendar year (CY) 2024. HSAG reviewed a sample of initial credentialing files and found that COA processed all records in a timely manner. Each initial credentialing file included Council for Affordable Quality Healthcare (CAQH) applications, evidence of license and education verification through the Colorado Department of Regulatory Agencies (DORA), verification of work history in the most recent five years, professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner in the most recent five years, and the Drug Enforcement Administration (DEA) verification and board certification verification, if applicable. HSAG also reviewed a sample of recredentialing files and found that COA appropriately recredentialed providers and organizations within the 36-month time frame. Further, COA provided evidence that it conducted ongoing monitoring of practitioners and organizations through National Practitioner Data Bank (NPDB) continuous query monitoring and DORA.

During the interview, COA described additional monitoring of practitioners and organizations that occurred between credentialing cycles, which included reviews of provider-specific member grievances and occurrences of adverse events, such as quality of care concerns. COA described a process that included direct lines of communication between COA's credentialing and quality management

departments, wherein any quality of care concerns were forwarded to the Credentialing Committee for further investigation and corrective action.

COA delegated credentialing and recredentialing activities to numerous contracted organizations. Annual monitoring of delegates was conducted by COA through a delegation audit, ensuring compliance with activities, responsibilities, and reporting. Per COA, delegates in recent years have been successful during the annual audit and met the 95 percent benchmark.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

COA had written policies and procedures for the selection and retention of its providers. While COA posted its credentialing policies on its website, COA did not post its policies and procedures for the selection and retention of providers on its website. COA must post its policies and procedures for the selection and retention of its providers publicly on its website.

Standard XI—EPSDT Services

Evidence of Compliance and Strengths

COA submitted comprehensive EPSDT policies, procedures, interactive voice response (IVR) scripts, and samples of outreach letters. These documents demonstrated adherence to a multi-stream outreach approach that engaged and informed pregnant members and members aged 20 and under about available benefits. COA used a vendor to conduct automated IVR calls for initial outreach, prenatal outreach, well-visit reminders, and postnatal care. COA reported an engagement rate above 90 percent for these calls; however, results were not available to indicate what percent of IVR engagement resulted in a scheduled appointment, including well-child and prenatal visits.

Upon transfer to care management, a member of the care management team followed detailed scripts that included assessing the member's specific physical health, mental health, and health-related social needs (HRSN) needs, such as housing, transportation, food assistance, utility assistance, smoking cessation, or other needs. COA staff members also worked with providers to remind them to request key transitional needs (such as renewing eyeglass prescriptions) before aging out of EPSDT and transitioning to adult care.

COA providers received EPSDT information through the provider manual and COA reported that it began incorporating EPSDT training into new provider onboarding training materials as of November 1, 2024.

Recommendations and Opportunities for Improvement

During the interview, the utilization management (UM) lead was not able to provide a summary of COA's approach regarding how it processes service requests with consideration to EPSDT medical necessity requirements. HSAG recommends that COA implement a refresher course, desktop procedure, checklist, or similar item to ensure all UM staff members are appropriately informed about EPSDT services and can ensure consistent application of EPSDT medical necessity requirements and referral practices.

During the review, COA noted that it could not determine whether direct mail outreach to new or existing members was successful due to the use of the nonprofit mail rate, which does not allow for return to sender for undeliverable mail. COA stated that it is working on a mechanism to track these outreaches to determine undeliverable addresses. HSAG recommends that COA consider using the first-class mail rate as an intervention to determine whether the rate of returned mail is worth the extra cost to connect with members that might be difficult to reach.

Required Actions

While COA was able to provide evidence of how providers were made aware of the Colorado Medicaid EPSDT program, COA did not provide evidence that trainings and updates on EPSDT were made available to network providers every six months during the period under review. COA must provide trainings and updates on EPSDT that are made available to network providers every six months.

3. Background and Overview

Background

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Health Care Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers (PCPs) and capitated behavioral health providers to ensure access to care for Medicaid members. In accordance with Title 42 of the Code of Federal Regulations (42 CFR), RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). The CFR requires PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PIHPs to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), HSAG.

To evaluate the RAEs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2024–2025 was CY 2024. This report documents results of the FY 2024–2025 compliance review activities for COA. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, RAE, and Department personnel who participated in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 20, 2024.

Overview of FY 2024–2025 Compliance Monitoring Activities

For the FY 2024–2025 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools for the four chosen standards:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing
- Standard XI—EPSDT Services

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2024–2025 compliance 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—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

The objective of the compliance 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, timeliness, and accessibility of 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.

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with COA until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

For FY 2023–2024, HSAG reviewed Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems.

Related to Standard V—Member Information Requirements, COA was required to complete one required action:

- Revise its provider directory to include the provider URLs.

Related to Standard VII—Provider Selection and Program Integrity, COA was required to complete one required action:

- Update its sanctions and exclusions policies and procedures to align in full detail with the federal and State requirements that COA would not knowingly employ any staff members who are debarred or suspended.

Related to Standard IX—Subcontractual Relationships and Delegation, COA was required to complete three required actions:

- Maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements and ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.
- Ensure that all contracts, including the contract with OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.

- Guarantee, via revisions or amendments, that subcontractor agreements include:
  - The State, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the contractor's contract with the State.
    - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
    - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Related to Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, HSAG found no required actions for this standard.

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in April 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to COA. COA submitted final documentation and completed the CAP in July 2024.

Summary of Continued Required Actions

COA successfully completed the FY 2023–2024 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk members and ensure active management of high-cost and high-need members. 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. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. • Is documented, for both medical and non-medical activities.	• CM100 Colorado Access Care Coordination ○ Definitions Care Coordination page 1-defines at a high-level what care coordination is and how it addresses member needs ○ Statement of Policy section page 2 highlights more in depth how the organization works with members and the care team to assess needs, connect to resources and develop care plans that are agreed upon by the member ○ 2. Facilitation of Care Coordination Section pages 5-7 discusses how members/family/caregivers are involved in process, how needs are assessed and interventions that occur after identifying the members needs. It discusses the care planning process, coordinating across multiple systems. **Guiding_Care_Screenshots for member preferences pages 8-9 demonstrate ways staff can capture member preferences in the care coordination tool**	☒ 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) Contract Amendment 17: Exhibit B—11.3.1, 11.3.7		
2. The RAE ensures that each behavioral health member has an ongoing source of care appropriate to the member's 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 the designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 17: Exhibit B—None	• RAE HSAG 2024 RAE New Member Booklet ○ Page 4 discusses care coordination and how to get in touch • RAE HSAG 2024 COA Website Screenshot Care Management Phone Number-see screenshot, has contact info on website to reach care management • CM100 Colorado Access Care Coordination ○ Page 5 2. Facilitation of Care Coordination number 3 discusses the care coordinator will share with member lead coordinator info and the care teams info to ensure member has those contacts.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing	COA supports member choice and the right to see whatever provider a member chooses; members are not prohibited from seeing a PCMP to whom the member is not attributed. Additionally, the Department has implemented a six-month reattribution process that reassigns members based on claims activity. This appears to be the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 17: Exhibit B—6.8.1	most effective method of ensuring members are attributed to providers with whom they have chosen to seek care, unless the member is seeing a provider who is not a RAE PCMP and just takes Medicaid. COA is also available to assist members in the event they have issues with a PCMP (the grievance team) or they wish to find a new provider, the care management team can assist members with locating a new PCMP.	
4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extensive assistance and include appropriate interventions. Contract Amendment 17: Exhibit B—11.3.3	• CM100 Colorado Access Care Coordination • DLP CM QRTP/PRTF-is an example of a workflow that documents the required activities for that program to ensure appropriate interventions along the members journey to QRTP/PRTF.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member:	• CM100 Colorado Access Care Coordination ○ Definitions- Care Coordination page 1-the definition includes pieces on coordinating with others ○ Purpose page 2-discusses coordinating across healthcare	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. • Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community. *Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings; and members residing in the community who are identified as at-risk for institutionalization.* *42 CFR 438.208(b)(2)* Contract Amendment 17: Exhibit B—14.1, 14.3, 11.3.10, 11.3.10.4.2.3, 11.3.20.2.1	settings, community agencies and with others ○ Statement of policy pages 2-4 ○ Entire Facilitation of Care-discusses all the ways we may help coordinate care for members Coordination pages 5-7 • CM101 Delivering Continuity and Transitions of Care to Members ○ Statement of Policy page 2-discusses we may coordinate with the other plan and others and share health information about member COA DLP Transitions of Care (Admissions and Discharge)-page 2 section 3. High level description numbers 3-8 discuss assisting with discharge RAE HSAG 2024 COA_DLP_Justice Involved discusses high level how we support members who are being released from incarceration.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 17: Exhibit B—7.5.2–3	**Both RAEs:** • CM DP11 RAE HNA This details the usage of health needs survey data and outreach process ○ Background ○ Procedure 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2–3)* Contract Amendment 17: Exhibit B—14.7.1	• CM100 Colorado Access Care Coordination ○ 2. Facilitation of Care Coordination number 2b numbers 1-3 page 5 discuss our assessments and what may be done with the assessment and who it may be shared with CM 101 Delivering Continuity and Transitions of Care to Members • Purpose page 2 describes how organization supports continuity of care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Statement of Policy page 2 discusses again how organization supports continuity of care • Continuity of Care and Transition of Care for New Members including Members with Special Health Care Needs/Special Populations/Complex Members1 page 3 discusses identifying these members and how we outreach and support them	
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 17: Exhibit B—None	• CM100 Colorado Access Care Coordination Facilitation of Care Coordination page 5 2b number 3 discusses that we may share with providers to mitigate duplication of efforts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable.	• PRI 100 Protecting Member PHI • PRI 101 Clinical Staff Use and Disclosure of Member PHI • PRI 103 Authorizations to Disclose Member PHI • PRI 104 Member Rights and Requests Regarding PHI • PRI 105 Personal Representatives and Member PHI	☒ 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) and (6) Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	• PRI 200 Sanctions Policy • PRI 204 Security of EPHI • COA Provider Manual Section 3 ○ Page 23 Patient Record Documentation	
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. The care coordination tool, at a minimum:	• Guiding Care Screenshots -the screenshots demonstrate what demographic information, sample of care notes, activities, staff roles and other key information that can be found in GuidingCare. RAE HSAG 2024-Healthedge Security Document- details measures Healthedge takes to keep data safe. The system does show eligibility based on the line of business and plan	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Works on mobile devices. • Supports HIPAA and 42 CFR Part 2 compliant data sharing. • Provides role-based access to providers and care coordinators. *Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.* Contract Amendment 17: Exhibit B—15.2.1.1, 15.2.1.2, 15.2.1.3–5		

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 17: Exhibit B—7.3.7.1–2	• CS212 Member Rights and Responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 17: Exhibit B—17.10.7.2	• ADM205 Nondiscrimination ○ Policy Statement • ADM230 Member Disability Rights Request and Complaint Resolution ○ Policy Statement • CS212 Member Rights and Responsibilities ○ Policy Statement second paragraph • Provider Manual Section 2 ○ Page 8 Nondiscrimination ○ Page 12 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/ ○ https://www.coaccess.com/nondiscrimination/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 17: Exhibit B—7.3.7.2.1–6	• CS212 Member Rights and Responsibilities ○ Policy Statement bulleted list • ADM208 Member Materials • Provider Manual Section 2 ○ Page 12 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the RAE, its network providers, or the Department treat(s) the member.	• ADM203 Member Grievance Process ○ Grievance Definition ○ Procedures Section 1 • Provider Manual Section 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.100(c) Contract Amendment 17: Exhibit B—7.3.7.2.7	○ Page 12 Member Rights and Responsibilities • COA Website ○ https://www.coaccess.com/members/services/rights/ • New Member Booklet ○ Page 41-44 (as identified in the booklet) ○ Health First Colorado Member Handbook	
5. For medical records and any other health and enrollment information that identify a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	• PRI100 Protecting Member PHI • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI • PRI104 Member Rights and Requests Regarding PHI • PRI105 Personal Representatives and Member PHI • PRI200 Sanctions Policy • PRI204 Security of EPHI • See COA Website ○ http://www.coaccess.com/documents/Notice-of-Privacy-Practices.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection. • 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.	• ADM331 Advance Directives ○ Policy statement ▪ 2nd paragraph ▪ 4th paragraph beginning with "Colorado Access will provide members" • PRI105 Personal Representatives and Member PHI • Provider Manual ○ Section 2 ▪ Advance Directives pages 13-14 • COA Website: ○ https://www.coaccess.com/members/services/ ▪ Advance Directives	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment.		

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
▪ Description of applicable State law concerning advance directives. *Note: The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 17: Exhibit B—7.3.11.2, 7.3.11.3.3		

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract Amendment 17: Exhibit B—9.3.5.2.1	• CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers • CR DP18 Credentialing Initial Providers • CR DP21 Recredentialing Practitioners • CR DP24 Organizational Credentialing Assessments The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse*	• CR301 Provider Credentialing and Recredentialing (pages 2-3) • CR305 Assessment of Organizational Providers (page 1) • PNS202 Selection and Retention of Providers The policies follow NCQA credentialing standards.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
specialists or psychiatric nurse practitioners, and other behavioral health care specialists. *42 CFR 438.214(a)–(b)(1)* NCQA CR1—Element A1 Contract Amendment 17: Exhibit B—9.1.6		
Findings: COA had written policies and procedures for the selection and retention of its providers. While COA posted its credentialing policies on its website, COA did not post its policies and procedures for the selection and retention of providers on its website.		
Required Actions: COA must post its policies and procedures for the selection and retention of its providers publicly on its website.		
2.B. The verification sources it uses. NCQA CR1—Element A2	• CR301 Provider Credentialing and Recredentialing (pages 8-11) • CR305 Assessment of Organizational Providers (pages 5-7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	• CR301 Provider Credentialing and Recredentialing (pages 11-13) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	• CR301 Provider Credentialing and Recredentialing (pages 11-13) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	• CR301 Provider Credentialing and Recredentialing (pages 11-15) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	• CR301 Provider Credentialing and Recredentialing (pages 3-4) • Signed Committee Confidentiality Non-discrimination Statements The policies follow NCQA credentialing standards, and the Committee members sign statements every year.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor.	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR1—Element A7	The Credentialing Coordinators reach out to the provider to allow them to make updates to their documentation as needed.	
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	• CR301 Provider Credentialing and Recredentialing (page 13) • CR305 Assessment of Organizational Providers (page 7) Approval letters are mailed every Monday for the previous week's approvals.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	• CR301 - Provider Credentialing and Recredentialing (pages 3, 13) • CR305 Assessment of Organizational Providers (page 7) • CR DP04 Ongoing Monitoring of Providers • CR DP23 Monthly Ongoing Monitoring of Sanctions The policies follow NCQA credentialing standards. The Senior Medical Director signs off on clean files daily and we have co-chairs to run the monthly Credentialing Committee meetings.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	• CR301 Provider Credentialing and Recredentialing (pages 4-5) • Signed Confidentiality and Non-discrimination Statements The policies follow NCQA credentialing standards. Files are maintained on a secured drive, and only certain staff have access to this drive.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	• CR301 Provider Credentialing and Recredentialing (page 13) • CR305 Assessment of Organizational Providers (pages 7-8) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights • Provider Manual (revised) Credentialing policies are posted on our website and in the provider manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights • Provider Manual (revised) The Credentialing Coordinators reach out to the provider to allow them to make updates to their documentation as needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights • Provider Manual (revised) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	• CR301 Provider Credentialing and Recredentialing (pages 1, 4-7, 11-13 • CR305 Assessment of Organizational Providers (page 7) • CR DP04 On-going Monitoring of Providers (pages 3-4) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	• Credentialing Committee Members • CR301 Provider Credentialing and Recredentialing (pages 4, 6-7, 11-13) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards. The Senior Medical Director signs off on clean files daily and the Credentialing Committee meets once a month.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days).	• CR301 Provider Credentialing and Recredentialing (pages 5, 8-11) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions.	• CMP206 Sanctions Screening • CR301 Provider Credentialing and Recredentialing (pages 10-11) • CR305 Assessment of Organizational Providers (pages 5-6) • CR DP04 On-going Monitoring of Providers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(d)(1) NCQA CR3—Element B	The policies follow NCQA credentialing standards.	
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	• CR301 Provider Credentialing and Recredentialing (pages 5, 7, 10) • CR305 Assessment of Organizational Providers (pages 2, 6) The policies follow NCQA credentialing standards. The Colorado CAQH application meets this standard.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	• CR301 Provider Credentialing and Recredentialing (page 2) • CR305 Assessment of Organizational Providers (page 1) The policies follow NCQA credentialing standards. Colorado Access has not had a late file in 2024.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A	• CR301 Provider Credentialing and Recredentialing (pages 7-8) • QM201 Quality of Care Concern Investigations • CMP206 Sanction and Exclusion Screening • CR DP04 Ongoing Monitoring of Providers The policies follow NCQA credentialing standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	• CR301 Provider Credentialing and Recredentialing (pages 7-8) • CR305 Assessment of Organizational Providers (page 7) • QM201 Quality of Care Concern Investigations • CR DP04 Ongoing Monitoring of Providers The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)* NCQA CR7—Element A1	• CR305 Assessment of Organizational Providers • CR DP04 Ongoing Monitoring of Providers The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	• CR305 Assessment of Organizational Providers (pages 2-4, 6-7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	• CR305 Assessment of Organizational Providers (pages 2-4, 6-7) • Office Site Visit Form The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Elements B and C	• CR305 Assessment of Organizational Providers (page 1) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has documentation that it assesses providers every 36 months. NCQA MBHO CR7—Elements D and E	• CR305 Assessment of Organizational Providers (page 1) • CR DP02 Organizational Assessment and File Audit The policies follow NCQA credentialing standards. Colorado Access has not had a late file in 2024.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The RAE shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department. Contract Amendment 17: B-13—9.1.6.5.5	A report is submitted monthly to the state, called the RAE Accountability Report, that contains information about Provider contracting timelines. R5 Monthly Credentialing Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual	• ADM223 Delegation • CR301 Provider Credentialing and Recredentialing (page 4) The policies follow NCQA credentialing standards. Credentialing Delegation Agreement June 2024	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A		
17. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**NA**	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
18. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement.	• ADM223 Delegation • CR301 Provider Credentialing and Recredentialing (page 4) • Delegation Audit Notification Letter • Delegation Audit Results Letter • Credentialing Delegation Tool Results • 2024 Delegation Audit Task Checklist The policies follow NCQA credentialing standards. The Delegation Audit Task Checklist, along with reminder tasks ensures the annual audits are completed timely.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C		
19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	CR DP15 Delegation Audit Process There have not been any corrective action plans for our list of delegates in the past year.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	97%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE onboards and informs members and their families regarding the services provided by EPSDT. This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance. Contract Amendment 17: Exhibit B—7.3.12.1, 7.6.2	**1. Policy_Procedures_EPSDT_Peds_NE_WCC_DR** Page 5-6: Newly Enrolled Procedure Detail, highlighted, describes our standard process for identifying newly enrolled/re-enrolled members and generating and uploading outreach files to our vendor so that member may be sent a newly enrolled inform within 60 days of eligibility determination. The timeline for generating and uploading outreach files ensure members are outreached within 60 days of eligibility information. Page 5: Well Child Check Procedure Detail, highlighted, describes our standard process for identifying and outreaching members, least one time annually, who have not had a well visit in the previous 12 months. The timeline for generating and uploading outreach files ensure members are outreached within 60 days of eligibility determination. The timeline for generating and uploading outreach files ensure members are outreached within 60 days of eligibility information. Page 6: Dental Reminder Procedure Detail, highlighted, describes our standard process for identifying and outreaching members, least one time annually, who have not had a dental visit in the previous 12 months. The timeline for generating and	☒ 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**
	uploading outreach files ensure members are outreached within 60 days of eligibility information. Page 13: DIRECT MAIL OUTREACH FILES, highlighted, describes our standard process for identifying members who are eligible for the Newly Enrolled, Well Child check, or Dental Reminder programs who could not be outreached via IVR, and creating and uploading the direct mail outreach files for each program. The timeline for generating and uploading outreach files ensure members are outreached within 60 days of eligibility information. 1. Below documents show evidence (highlighted) of providing messaging about the benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, via the Newly Enrolled, Well Child Check, and Dental Reminder programs. Attachment A-COA EPSDT Newly Enrolled 0 – 17 Letter Attachment B-COA EPSDT Newly Enrolled 18 – 20 Letter	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Attachment C-COA Well Visit Flyer ages 18-20 Letter Attachment D-COA Well Visit Flyer ages 0-17 Letter Attachment E-COA EPSDT Dental Reminder 0-17 Letter Attachment F-COA EPSDT Dental Reminder 18-20 Letter COA_EPSDT_Dental Reminder_IVR_combo script COA_newly enrolled IVR combo script COA_well visit IVR combo script 2. The Colorado Access website includes an EPSDT landing page providing information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.coaccess.com/members/care/epsdt/ **3. Policy_Procedures_EPSDT_Adults_Text4Baby** Page 2-3: Section II. Digital Engagement Outreach Policies & Procedures, highlighted, describes our standard process for identifying pregnant or recently delivered members and generating and uploading outreach files so that member may be sent a newly enrolled inform within 60 days of eligibility information. **1. R5_EPSDTPln_SFY23-24** The Region 5 EPSDT Annual Plan describes in detail our methods and process for outreaching members with the appropriate messaging and methods as described in 42 CFR § 441.56 and the State Medicaid Manual Part V, Section 5121 **Outreach processes and materials do not differ between regions.**	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 17: Exhibit B—7.6.6	1. Evidence of providing *written* approaches to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: Attachment A-COA EPSDT Newly Enrolled 0 – 17 Letter Attachment B-COA EPSDT Newly Enrolled 18 – 20 Letter Attachment C-COA Well Visit Flyer ages 18-20 Letter Attachment D-COA Well Visit Flyer ages 0-17 Letter Attachment E-COA EPSDT Dental Reminder 0-17 Letter Attachment F-COA EPSDT Dental Reminder 18-20 Letter 2. Evidence of using *automated calls* to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services:	☒ 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**
	COA_EPSDT_Dental Reminder_IVR_combo script COA_newly enrolled IVR combo script COA_well visit IVR combo script 3. Evidence of using *SMS (text message)* to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: Text4baby Medicaid Bank v1.9 **Page**: 7, 10, 13, 14, 19, 20, 21, 24, 30, 31, 37, 39, 40-51	
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 17: Exhibit B—12.9.2.1, 12.9.3	• UM104 EPSDT ○ Procedures Section 1 • Provider Manual Section 10, Pages 67-69 EPSDT Provider Onboarding Training Outline	☐ 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**
Findings: While COA was able to offer evidence of how providers were made aware of the Colorado Medicaid EPSDT program, COA did not have evidence ensuring that trainings and updates on EPSDT were made available to network providers every six months during the period under review.		
Required Actions: COA must provide trainings and updates on EPSDT to network providers every six months.		
4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). For the *Capitated Behavioral Health Benefit*, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed, and the date ordered.	• UM104 EPSDT ○ Policy Statement ○ Procedure 1 • Provider Manual Section 10 ○ Pages 67-69	☒ 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**
• 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 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
5. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and 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 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.4.C	• UM104 EPSDT ○ Section 3.A 2-6	☒ 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**
6. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider nor 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 17: Exhibit B—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	• UM104 EPSDT ○ Medical Necessity Definition	☒ 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 Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).* Contract Amendment 17: Exhibit B—14.5.7.1	• UM104 EPSDT ○ Policy Statement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Colorado Access RAE 5

Review Period:	1/1/2024–12/31/2024
Completed By:	Travis Roth
Date of Review:	12/10/2024
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Travis Roth

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC	LCSW	LPC	PsyD	LCSW	MD	LMFT	LPC	LCSW	LMFT
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Professional Counselor	Psychology	Licensed Clinical Social Worker	Psychiatry	Licensed Marriage Family Therapy	Licensed Professional Counselor	Licensed Clinical Social Worker	Licensed Marriage Family Therapy
Date of Completed Application [MM/DD/YYYY]	12/1/2023	11/13/2023	3/5/2024	3/11/2024	4/12/2024	4/8/2024	7/15/2024	5/9/2024	8/7/2024	9/20/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/19/2024	1/30/2024	3/11/2024	4/10/2024	5/8/2024	6/17/2024	7/29/2024	8/21/2024	9/5/2024	10/7/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	Yes	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	Met	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	NA	NA	NA	Yes	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	NA	NA	NA	Met	NA	NA	NA	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Colorado Access RAE 5

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	7	7	7	7	9	7	7	7	7
Compliant (Met) Elements	7	7	7	7	7	9	7	7	7	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**72**									
Total Compliant Elements	**72**									
Total Percent Compliant	**100%**									

Notes:

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

Prior to Credentialing Decision
- DEA or CDS certificate
- Education and training

180 Calendar Days
- Current, valid license
- Board certification status
- Malpractice history
- Exclusion from federal programs

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Colorado Access RAE 5

Review Period:	1/1/2024–12/31/2024
Completed By:	Travis Roth
Date of Review:	12/10/2024
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Travis Roth

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LCSW	MD	LPC	LCSW	PsyD	LCSW	PhD	LCSW	LPC	CNM
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Licensed Clinical Social Worker	Psychiatry	Licensed Professional Counselor	Licensed Clinical Social Worker	Psychology	Licensed Clinical Social Worker	Psychology	Licensed Clinical Social Worker	Licensed Professional Counselor	Certified Nurse Midwife
Date of Last Credentialing [MM/DD/YYYY]	2/3/2021	2/3/2021	4/30/2021	6/8/2021	7/26/2021	2/18/2021	9/15/2021	10/20/2021	11/22/2021	11/5/2021
Date of Recredentialing [MM/DD/YYYY]	1/5/2024	1/24/2024	3/25/2024	5/8/2024	6/14/2024	1/30/2024	8/7/2024	9/12/2024	10/1/2024	9/30/2024
Months From Initial Credentialing to Recredentialing	35	35	34	35	34	35	34	34	34	34
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	Yes	NA	NA	NA	NA	NA	NA	NA	Yes
Evidence of Board Certification Met? [VIII.6]	NA	Met	NA	NA	NA	NA	NA	NA	NA	Met
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	Yes	NA	NA	NA	NA	NA	NA	NA	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	Met	NA	NA	NA	NA	NA	NA	NA	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Colorado Access RAE 5

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	5	7	5	5	5	5	5	5	5	7
Total Compliant (Met) Elements	5	7	5	5	5	5	5	5	5	7
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**54**									
Total Compliant Elements	**54**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

   180 Calendar Days
   - Current, valid license
   - Board certification status
   - Malpractice history
   - Exclusion from federal programs

   365 Calendar Days
   - Signed application/attestation

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

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2024–2025 compliance review of COA.

Table C-1—HSAG Reviewers, COA Participants, and Department Observers

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
COA Participants	**Title**
Rachel Williamson	Manager of Compliance and Privacy
Marcy Mullan	Director of Compliance Programs
Lisa Hug	Director of Program Deliverables
Ward Peterson	Director of Enrollment and Child Health Plan Plus
John Priddy	Vice President of Health Plan Operations
Taylor Mitchell	Child Health Plan Plus Program Manager
Jamie Zajac	Director of Care Management
Marsha Aliaga-Dickens	Manager of Care Management
Thomas Mayo	Director of Utilization Management
Josette Hizon	Supervisor of Behavioral Health Utilization Management
Travis Roth	Manager of Credentialing and Provider Data
Kathy Nyberg	Legal Services Manager
Reyna Garcia	Senior Director of Customer Service
Kate Myers	Health Programs Specialist
Claire Peters	Director of Populations Health
Kris Cooper	Supervisor of Behavioral Health Utilization Management
Sheryl McCully	Manager of Utilization Management
Natasha Wade	Care Manager II
Ann Edelman	Chief Legal Officer and Vice President of Compliance
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2024–2025

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE must submit documents based on the approved timeline.

Table D-1—CAP Process

Step	Action
Step 1	**CAPs are submitted**
If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE 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, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and to proceed with resubmission.	
Step 4	**CAPs are closed**
Once the MCE has received Department approval of the CAP, the MCE will be instructed that it may proceed with the planned interventions and the CAP will be closed. RAE Accountable Care Collaborative 2.0 contracts end June 30, 2025. RAEs that continue to contract with the Department are encouraged to follow through on completion of their CAP(s) to ensure compliance with their new contract.	

The CAP template follows on the next page.

Table D-2—FY 2024–2025 CAP for COA

Standard VIII—Credentialing and Recredentialing
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *42 CFR 438.214(a)– (b)(1)* NCQA CR1—Element A1 Contract Amendment 17: Exhibit B—9.1.6
Findings
COA had written policies and procedures for the selection and retention of its providers. While COA posted its credentialing policies on its website, COA did not post its policies and procedures for the selection and retention of providers on its website.
Required Actions
COA must post its policies and procedures for the selection and retention of its providers publicly on its website.
Planned Interventions

Standard VIII—Credentialing and Recredentialing
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 17: Exhibit B—12.9.2.1, 12.9.3
Findings
While COA was able to offer evidence of how providers were made aware of the Colorado Medicaid EPSDT program, COA did not have evidence ensuring that trainings and updates on EPSDT were made available to network providers every six months during the period under review.
Required Actions
COA must provide trainings and updates on EPSDT to network providers every six months.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, credentialing, recredentialing, and organizational provider credentialing record review tool, sample records, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved FY 2024–2025 Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.