COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 Site Review Report

for

Colorado Community Health Alliance

Region 7

June 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2020–2021 site review activities for **Colorado Community Health Alliance Region 7 (CCHA R7**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2020–2021 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

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

Summary of Compliance Results

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

Table 1-1 presents the scores for **CCHA R7** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
VII. Provider Participation and Program Integrity	16	15	15	0	0	1	100%
VIII. Credentialing and Recredentialing	32	31	31	0	0	1	100%
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
X. Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**67**	**67**	**0**	**0**	**2**	**100%**

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

Table 1-2 presents the scores for **CCHA R6** and **CCHA R7** combined for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	86	86	0	14	100%
Recredentialing	90	75	75	0	15	100%
Totals	**190**	**161**	**161**	**0**	**29**	**100%**

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

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

HSAG found that **CCHA**'s policies pertaining to the selection and retention of providers were comprehensive and effectively depicted the processes **CCHA** used to recruit, select, contract, and retain providers. **CCHA**'s *Request to Join Provider Network* policy noted that the RAE is willing to recruit and contract with any provider in good standing with CMS and enrolled in the Colorado Medicaid Program. **CCHA** used service data and member inquiry trends to identify and prioritize recruiting efforts and gaps in the network. Procedures described the steps and individuals responsible for requesting provider information, reviewing submissions, documenting requirements, and obtaining signatures. **CCHA** provided written notification in the event of denying a provider's request to join the network.

The provider manual contained the statement that providers must sign a contract or agreement with **CCHA** and documented requirements for each provider. **CCHA**'s BH and physical health (PH) provider manuals stated that practitioners would not be prohibited or restricted from advising members when acting within the lawful scope of their specialties. Network adequacy, member requests, and provider availability after hours were also considered in the BH and PH contracting processes.

CCHA offered BH and PH provider education through virtual regional town hall meetings, and monthly "open microphone" meetings to update network providers on new information and respond to questions. **CCHA**'s practice support team offered several types of assistance to providers, including help with billing and coding issues, data sharing, and care coordination. Practice transformation coaches supported the larger PH practices.

HSAG reviewed **CCHA**'s regional *Compliance Plan* and policies, which addressed staff and provider education and compliance activities that included claims reviews, data mining, auditing, and risk assessments. **CCHA** sent monthly letters to a sample of **CCHA** members verifying that services billed had been received by the member. The methodology and sample were clear and adequate.

CCHA's Compliance Committee managed local compliance activities, and the compliance officer reported quarterly to the **CCHA** board. Compliance policies included procedures for monitoring, auditing, and investigating potential compliance issues. **CCHA** trained employees to recognize and submit concerns about fraud, waste, or abuse to the Special Investigations Unit (SIU). **CCHA** tracked claims overpayments and conducted follow-up and data mining to monitor trends as needed. **CCHA** shared examples of reports submitted to the Department detailing provider overpayments and potential fraud for the region. **CCHA**'s *Excluded Individuals and Entities Prohibition on Hiring or Contracting* policy and *Credentialing* policy each stated **CCHA**'s commitment to and procedures for verification and notification regarding excluded individuals. **CCHA** provided evidence of a monthly review process for the United States Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities and the System for Award Management for current providers, board members, employees, and contractors. Employees were trained on compliance at the time of hire

and annually. Employee and contracted vendor training included standardized compliance education and a review of the organization's *Code of Business Conduct and Ethics* that required a signature acknowledgment from each staff member.

Summary of Findings Resulting in Opportunities for Improvement

CCHA included clear details about how a provider can notify **CCHA** and help members if the provider has any moral or religious objections. However, although **CCHA** does not object to any required services based on moral or religious reasons, this was not clearly communicated to the provider network in the BH or PH provider manuals. HSAG recommends that these sections be updated to further clarify that, while an individual provider may have such objections, **CCHA** as an organization does not.

While standardized, annual compliance training was provided to all staff members at the time of hire and annually thereafter, HSAG recommends **CCHA** expand on the expected training and education for management and program integrity staff members within compliance plan documents.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

CCHA's established policies, procedures, and supporting documents demonstrated systems in place to ensure that all credentialing and recredentialing requirements meet the National Committee for Quality Assurance (NCQA), federal, and State specifications and requirements. **CCHA**'s *Credentialing* policy clearly outlined operational processes and procedures for evaluating initial and recredentialing applications, verifying required credentialing elements, applicant record approval, decision making to determine denial or disenrollment of network participation, and notification of determination. **CCHA**'s policy also included a detailed section on the measures taken to ensure that no applicant is discriminated against for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein. **CCHA** conducted an annual review of the denial and terminations for consistency and to confirm nondiscriminatory practices in the selection of practitioners. **CCHA**'s annual nondiscriminatory credentialing and recredentialing report review identified trends and comparisons from 2019 to 2020. **CCHA**'s report findings determined that the top reason for denials and terminations in 2020 was practitioners who were not board certified and those with license/board actions. **CCHA**'s annual review indicated that there were no incidents of discrimination. To further demonstrate **CCHA**'s commitment to ensuring that credentialing and recredentialing processes were

conducted in a nondiscriminatory manner, the Credentials Committee meeting agenda incorporated ethics and conduct expectations as a reminder for all committee members.

Prior to the review, HSAG randomly selected five credentialing, five recredentialing, and four organizational provider administrative records to assess compliance with federal regulations and contract requirements related to credentialing and recredentialing of practitioners, and assessment of organizational providers (e.g., inpatient facilities, residential facilities, and ambulatory/outpatient facilities). Review of the administrative records approved on or between January 1 and December 31, 2020, demonstrated **CCHA**'s timely primary source verification of licenses, education/training, work history, history of professional liability, State/Medicaid sanctions/exclusions, and practitioner applications/attestations.

Summary of Findings Resulting in Opportunities for Improvement

CCHA's *Credentialing* policy noted that information regarding practitioner education and/or training conveyed to members through directories (physical and electronic) is the same verified information provided by the practitioners and organizations through the credentialing process. During the interview, **CCHA** staff members described the flow of provider data from the Cactus and BPM systems, the provider data management systems, to the Master Data database that houses all provider and group information. **CCHA** submitted a procedure, *Data Validation of Master Data and Supplemental Resources*, to further demonstrate this process. HSAG recommends that **CCHA** expand the verification process to include ongoing methods for ensuring data are updated and accurate. Additionally, HSAG recommends that **CCHA** update the *Credentialing* policy to reference that the validation process for credentialing data includes education, training, certification (including board certification, if applicable), and specialty.

CCHA's *Credentialing* policy detailed ongoing monitoring that occurs between recredentialing cycles, including all sources that were verified every 30 days and a lists of example actions that could be taken against a practitioner that no longer meets the required credentialing criteria, professional conduct, and/or quality standards. During the on-site interview, **CCHA** distinguished the formal process executed by its grievance and appeals department to review and track member grievances, potential quality issues (PQIs), and preventable adverse events (PAEs). **CCHA** submitted its *Member Grievance, PQI and PAE Processes* policy to further demonstrate the comprehensive Quality of Care and Service tables, which categorized quality of care issues and trends by severity with a level and point system. This information was shared with the credentialing department. Additionally, the appeal process section in the *Credentialing* policy explained that some terminated practitioners are not eligible for informal review/reconsideration or formal appeal. After further discussion during the on-site interview, **CCHA** reported that instances of immediate termination are in alignment with **CCHA**'s *Accountable Care Network (ACN) Agreement* and *Provider Agreement* contract language. HSAG recommends that **CCHA** add detail to the *Credentialing* policy, explaining those instances of immediate termination based on contract language and resulting in no formal appeal rights.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

CCHA identified six established delegated administrative agreements for services and responsibilities ranging from provider credentialing, language interpretation and translation services, and care coordination services. **CCHA** maintained a set of policies that described the mechanisms in place for delegation and oversight of delegated activities. **CCHA** provided a comprehensive set of documents that reflected ongoing reporting and oversight activities that included annual credentialing delegation audit reports. Oversight was provided by the department associated with delegated function, and delegation activities were described in a delegation policy for each functional area. The majority of delegated activities were related to credentialing and recredentialing.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

CCHA's Region 7 RAE Quality Improvement Plan documented a comprehensive quality assessment and performance improvement (QAPI) program that described the leadership structure, goals and objectives, and program components encompassing both PH and BH. **CCHA** established a multidisciplinary Quality Management Committee, identified priority populations and programs, and noted processes related to each component of the QAPI program. **CCHA** implemented two performance improvement projects that demonstrated positive progress until early discontinuation due to the coronavirus disease 2019 (COVID-19) pandemic. **CCHA**'s Region 7 RAE Quality Improvement Plan addressed key performance indicators and performance pool measures and described an improvement initiative for each measure that frequently included provider or practice engagement. Progress toward

goals was monitored through performance dashboards. **CCHA** coordinated multi-disciplinary team meetings to address the needs of children involved with the child welfare system, including strategy meetings between family and providers. Mechanisms were in place to detect and address over- and underutilization of services, which included major components of both the Potentially Avoidable Cost Plan and the Client Overutilization Program. In collaboration with community providers, **CCHA** implemented pilot programs targeted to specific populations to decrease hospital readmissions and inappropriate emergency department use.

CCHA established processes to identify, report, and investigate quality of care concerns, including a referral form made available to providers and **CCHA** staff members. **CCHA**'s member-facing staff members were trained to help recognize and document PQIs. Additionally, **CCHA** facilitated meetings with providers to address quality of care trends and opportunities for improvement. Clinical practice guidelines were evaluated, adopted, and distributed in compliance with requirements.

Member satisfaction was evaluated using various methods that included member survey results, grievance and appeal data, and call center data. Member Advisory Committee and Program Improvement Advisory Committee meetings also offered frequent opportunities for QAPI input from members, stakeholders, and residents of the communities served.

CCHA submitted health information system documents that provided a structural overview and outlined the data validation processes used. **CCHA** verified the accuracy and timeliness of reported data and screened the data for completeness, logic, and consistency. Data were collected using standardized formats. The health information system collected and provided claims, encounters, grievance, appeal, utilization, and disenrollment data. **CCHA** reviewed member disenrollment data for trends at the member, provider, and plan levels and offered support to unknowingly or incorrectly disenrolled members. Encounter file submissions were completed and submitted as required by the Department.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required corrective actions for this standard.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2020, through December 31, 2020. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials.

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

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

outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

Objective of the Site Review

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

- The RAE's compliance with federal healthcare regulations and managed care contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **CCHA R7** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals. **CCHA R7** was required to address four partially met elements for coverage and authorization, one not met requirement for access and availability, and nine partially met grievance and appeal requirements.

Summary of Corrective Action/Document Review

Regarding Standard I—Coverage and Authorization of Services, **CCHA R7** was required to:

- Update the definition of medical necessity to include all related criteria.
- Ensure, when appropriate, **CCHA R7** outreaches providers for additional information needed for authorization decisions.
- Develop a mechanism to ensure that the notice of adverse benefit determination (NABD) 1) is sent to members on time and 2) includes language that is easy for the member to understand.

Regarding Standard II—Access and Availability, **CCHA R7** was required to develop and implement a mechanism to conduct regular time and distance calculations to monitor State standards, specifically to ensure the member has two primary care medical provider choices within the member's ZIP Code or within maximum time and distance standards for the urban or rural geographic areas.

For Standard VI—Grievances and Appeals, **CCHA R7** was required to:

- Develop a mechanism to ensure that 1) clinical grievances are reviewed and resolved by a staff person with appropriate clinical expertise, 2) grievance resolution letters are written in language that

is easy for the member to understand and is mailed within 15 working days or the member receives a written extension if the grievance cannot be resolved within 15 working days, and 3) the resolution letter thoroughly addresses the member's specific complaint.

- Develop a mechanism to ensure that appeals are resolved within required time frames and resolutions are written in language that is easy for the member to understand.
- Develop an extension notice for grievances and appeals that includes required content (i.e., the reason for the extension, the right to file a grievance if the member disagrees with the extension) and improves the clarity of the language in the letter, and ensure the letters are sent to the members within the applicable time frames.
- Update policies to address 1) all content required in the appeal resolution letter, clarify continuation of benefits, ensure continuation of benefits is only included when applicable, and clarify how the member should request continued benefits; 2) time frames for continuation of benefits and criteria for requesting benefits; and 3) clarify how long benefits will continue.
- Update provider information to address inaccuracies or incomplete information regarding grievance and appeal information.

Summary of Continued Required Actions

CCHA R7 successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract Amendment #4: Exhibit B-4—9.1.6	*All documents in every standard apply to both regions unless explicitly noted.* The following documents outline selection and retention policies and procedures for CCHA physical health providers. • *VII.PPPI.1_Request to Join Provider Network - PCMP Policy, entire document* • *VII.PPPI.1_Processing PCMP Changes Policy, entire document* • *VII.PPPI.1_Adding PCMP Locations to a Group Policy, entire document* • *VII.PPPI.1_Physical Health Provider Manual, p. 29* The following document demonstrates that CCHA's selection and retention criteria is posted to the public website. • *VII.PPPI.1_Provider Network Qualifications, entire document* The following document describes how CCHA recruits and contracts with new providers and applicable circumstances for recruiting new providers to join its network. • *VII.PPPI.1_CCHA Annual BH Recruitment Strategy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines which provider types CCHA contracts with to ensure it has an adequate network to meet the needs of its membership. • *VII.PPPI.1_Provider Network Adequacy and Access Standards Policy, p. 2-3, 6* The following document outlines the policy and procedures for credentialing behavioral health providers into CCHA's network. Anthem manages the credentialing and recredentialing process for CCHA. • *VII.PPPI.1_Credentialing Policy, p. 1-2* The following document outlines CCHA's provider support and practice transformation strategies that aid in provider retention. • *VII.PPPI.1_R6_PracSupportPln_FY20-21, entire document* • *VII.PPPI.1_R7_PracSupportPln_FY20-21, entire document*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* RAE Contract Amendment #4: Exhibit B-4—9.3.4.2.1; 9.3.5	For RAE—applies only to BH providers The following document outlines CCHA's credentialing and recredentialing process for behavioral health providers, which follows NCQA standards. • *VII.PPPI.1_Credentialing Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.1-2	The following documents outline the non-discrimination policies as they apply to physical health providers. • *VII.PPPI.1_Request to Join Provider Network - PCMP Policy, p. 2* • *VII.PPPI.1_Physical Health Provider Manual, p. 30* The following section of the provider manual outlines the rights of CCHA behavioral health providers, including the right to not be discriminated against for acting within the scope of their licensure, as well as the right to not be discriminated against for treating certain populations of CCHA members. • *VII.PPPI.3_Behavioral Health Provider Manual - Provider Rights, p. 1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines the non-discrimination policy for CCHA's Credentialing program. • *VII.PPPI.1_Credentialing Policy, p. 5*	
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.4	The following document states that CCHA will notify providers in writing if CCHA declines to include an individual provider or group in its PCMP network. • *VII.PPPI.4_PCMP License Screening Process, p. 2* The following document demonstrates how CCHA documents when a provider's request to join the PCMP network is denied. • *VII.PPPI.4_CCHA RTJ Denial Tracker, entire document* The following document provides an example of the written notification a provider would receive if CCHA were to decline their request to join the PCMP network, stating the reason for CCHA's decision. • *VII.PPPI.4_CCHA Denial for License Issues Template Letter, entire document* The following letter is used to notify SUD providers wanting to join CCHA's network that our network is currently closed to additional providers. CCHA maintains an open network for all other behavioral health provider types.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VII.PPPI.4_CCHA SUD Benefit Network Closed Letter, entire document* The following section of the Credentialing Policy outlines how CCHA notifies providers of the decision to decline or terminate participation in CCHA's network. • *VII.PPPI.1_Credentialing Policy, p. 4-5*	
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract Amendment #4: Exhibit B-4—9.1.13	The following documents are the standard contract templates that CCHA uses to contract with physical health providers in its network. • *VII.PPPI.5_CCHA PCMP Agreement Template, entire document* • *VII.PPPI.5_CCHA ACN Agreement Template, entire document* The following document includes a statement that PCMPs must sign agreements. • *VII.PPPI.1_Physical Health Provider Manual, p. 29-30* The following documents provide evidence that CCHA enters into signed contracts with each provider in the network. • *VII.PPPI.5_R6 Network Adequacy Plan, p. 3* • *VII.PPPI.5_R7 Network Adequacy Plan, p. 3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is the template base contract CCHA uses to contract with providers. • *VII.PPPI.5_CO RAE BH Contract Template, entire document* The following document outlines the steps to become a BH provider with CCHA, including the requirement to have a dually signed contract in place before the provider can be considered a CCHA provider. • *VII.PPPI.5_CCHA BH Provider Recruitment Sheet, entire document*	
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—9.1.15, 17.9.4.2.5, 17.10.5.1-2	The following document states that CCHA will not employ or contract with anyone excluded from participation in federal or state health care programs and outlines procedures for monitoring against OIG. • *VII.PPPI.6_Excluded Individuals and Entities Policy, p. 2* The following document demonstrates that CCHA does not employ or contract with providers excluded from participation in federal or state health care programs and outlines the procedure to verify provider eligibility against the OIG List of Excluded Individuals. • *VII.PPPI.1_Request to Join Provider Network - PCMP Policy, p. 2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following policy demonstrates providers who are excluded from participation are immediately denied. • *VII.PPPI.4_PCMP License Screening Process, p. 1* The following document includes a statement that CCHA does not employ or contract with providers excluded from participation in federal or state health care programs and outlines the procedure to verify provider eligibility. • *VII.PPPI.1_Physical Health Provider Manual, p. 30* The following contract templates include a statement that the signing entity it is not an excluded provider and will notify CCHA if it receives notice that is excluded. • *VII.PPPI.5_CCHA PCMP Agreement Template, p. 8* • *VII.PPPI.5_CCHA ACN Agreement Template, p. 13* The following document outlines the process by which providers are continuously monitored on the listed government agencies websites for exclusion of participation. • *VII.PPPI.6_Kchecks User Guide, p. 1*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following documents include logs of potential matches to providers in the CCHA system during the monthly KChecks monitoring, which are then resolved or verified in the Notes Report. • *VII.PPPI.6_KChecks Matches, entire document* • *VII.PPPI.6_KChecks Notes Report, entire document* The following sections speak to CCHA's requirement to not credential or recredential any behavioral health applicant that is sanctioned/debarred/excluded from participation in federal health care programs, as well as CCHA's monthly monitoring of the LEIE. • *VII.PPPI.1_Credentialing Policy, p. 10, 13, 30-31* The following section of the policy confirms CCHA's requirement to not contract with excluded providers during the provider recruitment process. • *VII.PPPI.1_CCHA Annual BH Recruitment Strategy, p. 1-2*	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610*	The following section of the policy reflects CCHA's requirement to not knowingly have an excluded director, partner, officer, subcontractor, employee, consultant, or owner/beneficial owner. • *VII.PPPI.6_Excluded Individuals and Entities Policy, p. 2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract Amendment #4: Exhibit B-4—17.9.4.2.1-4	The following documents are CCHA's required Ownership and Control Disclosure submission where CCHA attests to not knowingly having an excluded director, partner, officer, subcontractor, employee, consultant, or owner/beneficial owner. • *VII.PPPI.7_CCHA Ownership and Control Disclosure FY20-21, entire document* • *VII.PPPI.7_CCHA Ownership and Control Disclosure FY20-21 Attachment, entire document*	
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract Amendment #4: Exhibit B-4—14.7.3	The following document includes this statement. • *VII.PPPI.1_Physical Health Provider Manual, p. 21* The following section of the provider manual confirms that CCHA providers will not be prohibited or restricted by CCHA for advocating on behalf of their patients. • *VII.PPPI.3_Behavioral Health Provider Manual - Provider Rights, p. 1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* RAE Contract Amendment #4: Exhibit B-4—7.3.6.1.13-14, 14.4.7	Not Applicable. CCHA does not object to providing any covered service on the basis of moral or religious grounds, so this item is deemed to be non-applicable. However, if CCHA becomes aware of a situation where a network provider wishes to not provide such services, CCHA will support the member as indicated in the following documents: • *VII.PPPI.1_Provider Network Adequacy and Access Standards Policy, p. 3, 4, 5* • *VII.PPPI.9_ Advance Directives Policy, p. 2* • *VII.PPPI.1_Physical Health Provider Manual, p. 13* • *VII.PPPI.9_Member Rights and Responsibilities Policy, p. 2*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: CCHA included clear details about how a provider can notify CCHA and help a member if the provider has any moral or religious objections. However, although CCHA does not object to any required services based on moral or religious reasons, this was not clearly communicated to the provider network in the BH or PH provider manuals. HSAG recommends that these sections be updated to further clarify that, while an individual provider may have such objections, CCHA as an organization does not.		
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements.	The CCHA Compliance plans speak to the overall Compliance Program, including the Code of Conduct, supporting policies and procedures, designation of the Plan Compliance Officer, the Compliance Committee's roles and responsibilities, and training and communication of applicable staff.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract Amendment #4: Exhibit B-4—17.1.3, 17.1.5.1-7	• *VII.PPPI.10_R6CompliancePlnFY20-21, p. 4* • *VII.PPPI.10_R7CompliancePlnFY20-21.The R7 Compliance plan mirrors the R6 plan. The R6 plan is annotated.* As CCHA is a joint venture between Anthem and Physician Health Partners (PHP), employees from both companies work for and on behalf of CCHA. The Codes of Conduct from both Anthem and PHP are provided that demonstrate the standards of conduct and commitment to comply with all applicable laws and policies and procedures. • *VII.PPPI.10_Anthem Code of Conduct, entire document* • *VII.PPPI.10_PHP Code of Conduct, entire document* The following policy outlines how Compliance performs and refers internal investigations of Compliance issues, including the disciplinary measures an associate may experience due to the outcome of an investigation. • *VII.PPPI.10_Compliance Investigations Policy, entire document* The following document outlines how Compliance performs routine monitoring and enacts audit plans. • *VII.PPPI.10_Compliance Monitoring and Auditing Policy, entire document*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following documents all support CCHA's Compliance plan and our adherance. • *VII.PPPI.10_Reporting of Fraud Abuse Investigations Policy, entire document* • *VII.PPPI.10_Provider Payment Suspension Policy, entire document* • *VII.PPPI.10_Provider Termination with Cause Policy, entire document.* • *VII.PPPI.10_Member Verification of Services Policy, entire document* • *VII.PPPI.10_Reporting Change in Member Circumstance Policy, entire document* • *VII.PPPI.1_Credentialing Policy, entire document* • *VII.PPPI.6_Excluded Individuals and Entities Policy, entire document* • *VII.PPPI.10_Anthem SIU Antifraud Plan, entire document*	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit.	The following documents apply to PHP employees who work for or on behalf of CCHA. • *VII.PPPI.11_False Claims Act Policy, entire document* • *VII.PPPI.11_Fraud Waste and Abuse Policy, entire document* • *VII.PPPI.11_PHP FWA Training Attestation 2021, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6-8)* RAE Contract Amendment 4: Exhibit B-4—17.1.6, 17.1.5.9, 17.7.1, 17.5.1	The following document reminds the provider network of the requirement to complete annual Fraud, Waste, and Abuse training. • *VII.PPPI.11_CCHA Provider Newsletter Feb 2021, p. 2* The following document includes detailed information about the False Claims Act, including nonretaliation protections for reporters, where to report suspected violations directly, and provisions for suspension of payments. • *VII.PPPI.1_Physical Health Provider Manual, p. 19* The following document provides evidence that provisions are in place to suspend payments for physical health network providers when directed to do so by the state. • *VII.PPPI.11_PH Suspended Payments Policy, entire document* The following document provides additional information to Anthem associates regarding the False Claims Act. • *VII.PPPI.10 Anthem Code of Conduct, p. 29* The following document outlines the operations and processes of the Anthem Special Investigations Unit, which includes developing and maintaining relationships with the State Medicaid Fraud Control Unit.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VII.PPPI.10_Anthem SIU Antifraud Plan, entire document* The following policy provides guidance for the False Claims Act to Anthem employees, including whistleblower protections and non-retaliation policy. • *VII.PPPI.11_Fraud Waste and Abuse Detection and Prevention in Health Plan Operations Policy, entire document* The following section of the Program Integrity Plan outlines how Compliance and Program Integrity work together to enforce associate compliance with state and federal laws, including the Deficit Reduction Act of 2005. • *VII.PPPI.11_2021 CO Program Integrity Plan, p. 27* The following policy outlines the procedure Compliance follows when HCPF notifies CCHA to suspend payments to a behavioral health provider due to credible allegations of fraud. • *VII.PPPI.10_Provider Payment Suspension Policy, entire document* The following policy outlines the requirements for reporting suspected fraud, waste, and abuse to the appropriate State agencies by Anthem's SIU.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VII.PPPI.10_Reporting of Fraud Abuse Investigations Policy, entire document* The following is the form CCHA uses to notify HCPF and the MFCU of suspected provider fraud. • *VII.PPPI.11_Suspected MCO Fraud Notice Template, entire document*	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.7.2-5, 17.1.5.7.1, 17.1.5.7.6, 17.3.1.3.2.1, 17.3.1.1.2.3-4, 17.3.1.3.1.1	The following document outlines the procedure to notify the state when a physical health network provider is terminated from the CCHA network or closes their practice. • *VII.PPPI.12_Notice of a Provider Termination or Practice Closure Policy, entire document* The following document outlilines the procedure to notify the State when a network provider is terminated from the CCHA physical health network. • *VII.PPPI.12_PCMP Network Disaffiliation Procedure, entire document* The following documents include CCHA's procedure and template to notify the state when there is a change in a member's circumstance that may affect the member's eligibility, including change in member residence and death. • *VII.PPPI.10_Reporting Change In Member Circumstance Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VI.PPPI.12_Reporting Member Change Template, entire document* The following policy outlines how CCHA verifies members did receive services billed by their providers through claims sampling. • *VII.PPPI.10_Member Verification of Services Policy, entire document* The following policy describes the process for terminating a CCHA network behavioral health provider for cause, including notification to HCPF. • *VII.PPPI.10_Provider Termination with Cause Policy, entire document* The following section of the policy outlines the requirements under the False Claims Act to return overpayments due to fraud to the State within under the False Claims Act to return overpayments due to fraud to the State within 60 calender days. • *VII.PPPI.11_Fraud Waste and Abuse Detection and Prevention in Health Plan Operations Policy, p. 13* The following section of the Program Integrity Plan outlines the requirement of Program Integrity and SIU to report all overpayments to the appropriate agencies.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VII.PPPI.11_2021 CO Program Integrity Plan, p. 32* The following policy outlines the process for reviewing and processing overpayments, including those related to suspected fraud. • *VII.PPPI.12_Overpayments Policy, entire document* The following documents are the biannual consolidated Fraud, Waste, and Abuse reports, which are a summary of audits and overpayments, submitted suspected provider and member fraud reports, as well as member service verfication notices sent during the reporting period. • *VII.PPPI.12_R6_FWARpt_Q1Q2FY20-21, entire document* • *VII.PPPI.12_R7_FWARpt_Q1Q2FY20-21, entire document* The following document is an example of our monthly submissions to HCPF that documents suspension of provider payments, overpayment recoveries, and changes in provider circumstances, including termination from CCHA's network. • *VII.PPPI.12_R6 Monthly FWA Report 07-20, entire document*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *VII.PPPI.12_R7 Monthly FWA Report 07-20, entire document*	
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608(b)* RAE Contract Amendment #4: Exhibit B-4—9.2.1.1, 9.3.2, 17.9.2	The following document demonstrates how CCHA ensures and requires providers are enrolled with Health First Colorado prior to contracting to become part of the CCHA physical health network. • *VII.PPPI.1_Request to Join Provider Network - PCMP Policy, p. 2* The following document on our website outlines the requirement for providers to be enrolled with Medicaid prior to contracting with CCHA, as well as CCHA's requirement to not extend an agreement until all Health First Colorado enrollment and credentialing is approved. • *VII.PPPI.5_CCHA BH Provider Recruitment Sheet, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract Amendment #4: Exhibit B-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	The following policy outlines our requirement to notify appropriate state agencies of any excluded individuals. • *VII.PPPI.6_Excluded Individuals and Entities Policy, p. 3* The following policy outlines CCHA's requirement to notify HCPF of its ownership or controlling interests, as well as the procedure for submitting notifications due to changes and/or at contractually required time periods. • *VII.PPPI.14_Disclosure of Change In Ownership or Controlling Interest Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following documents are the required state submission where CCHA provides written disclosure of any prohibited affiliations, as well as applicable ownership and control information. • *VII.PPPI.7_CCHA Ownership and Control Disclosure FY20-21, entire document* • *VII.PPPI.7_CCHA Ownership and Control Disclosure FY20-21 Attachment, entire document* The following policy outlines the process to identify and adjust excess capitation payments or other payments from the State. • *VII.PPPI.14_Premium Discrepancy Report Resolution Process, entire document*	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.8, 17.3.1.2.4.4	The following document outlines the requirements for CCHA providers regarding overpayments. • *VII.PPPI.5_CO RAE BH Contract Template, p. 4* The following section of the BH provider manual informs providers on the overpayment recovery process, including where to find applicable forms, contact information, as well as applicable laws and regulations regarding overpayments. • *VII.PPPI.15_Behavioral Health Provider Manual - Claims Overpayment Recovery Procedure, p. 1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is an example of the first notice sent to a CCHA provider when we identify an overpayment, which includes how to return payment to CCHA and how to dispute the request. • *VII.PPPI.15_Provider Overpayment Request Letter First Notice, entire document* The following document is an example of the final notice sent to a CCHA provider when we identify an overpayment, which includes how to return payment to CCHA and how to dispute the request, as well as actions CCHA will take to offset the overpayment if not received. • *VII.PPPI.15_Provider Overpayment Request Letter Final Notice, entire document* The following document is the biannual consolidated Fraud, Waste, and Abuse report, which is a summary of audits and overpayments, submitted suspected provider and member fraud reports, as well as member service verfication notices sent during the reporting period. • *VII.PPPI.12_R6_FWARpt_Q1Q2FY20-21, entire document* • *VII.PPPI.12_R7_FWARpt_Q1Q2FY20-21, entire document*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract Amendment #4: Exhibit B-4—14.14.1-2, 17.14.2-4	The following document demonstrates that members cannot be be held financially liable for services covered by Health First Colorado, be charged for scheduling appointments, missed or cancelled appointments. All medically necessary covered services are offered to all members. • *VII.PPPI.1_Physical Health Provider Manual, p. 12* The following section of the provider manual outlines CCHA's requirements that members are not held liable for its debts and/or debts of a CCHA provider. • *VII.PPPI.16_Behavioral Health Provider Manual - Billing Members, entire document* The following section of the provider contract holds CCHA members harmless from providers seeking payment from members for Medicaid covered services. • *VII.PPPI.5_CO RAE BH Contract Template, p. 20*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RAE Contract Amendment #4: Exhibit B-4- 9.3.4.2.1	Note: These are NCQA MBHO requirements available at the time of drafting this tool (6/2020). The following document outlines the process used to credential behavioral health providers under CCHA. Anthem manages credentialing of behavioral health providers for CCHA. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *42 CFR 438.214(a)* NCQA CR1—Element A1	The following document outlines the process used to credential behavioral health providers under CCHA. Anthem manages credentialing of behavioral health providers for CCHA. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	The following document outlines the verification sources used to credential CCHA BH providers. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 6*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	The following document outlines the criteria for credentialing and recredentialing CCHA BH providers. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 10-20*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	The following document outlines the roles and responsibilities of the Credentials Committee, the internal group tasked with making credentialing and recredentialing decisions. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 3-5*	☒ 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	The following document outlines the process for managing credentialing files. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 22-25*	☒ 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: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	The following document outlines the non-discrimination policy for providers being credentialed in CCHA's BH network. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 5*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	The following document outlines the process for a practitioner to review and verify information during the Credentialing process. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	The following document outlines the process for notifying providers of the credentialing decision within 60 calendar days. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 4-5*	☒ 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	The following document outlines the participation of the chair/vice-chair of the Credentials Committee and the needed qualifications. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 4, 5*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	The following document outlines the process for maintaining confidentiality for the information provided during the credentialing process. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 4*	☒ 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	The following document outlines how information provided during the credentialing process is provided to CCHA members. • *VIII.CR.1-2K_2020 Credentialing Policy, p. 25-26*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	The following section affirms CCHA's requirement to notify providers of their right to review submitted information. • *VIII.CR.3_2020 Credentialing Policy, p. 4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	The following section outlines how providers are notified of their ability to correct erroneous information. • *VIII.CR.3_2020 Credentialing Policy, p. 4*	☒ 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	The following section affirms CCHA's requirement to provide the status of their application upon request. • *VIII.CR.3_2020 Credentialing Policy, p. 4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	The following section provides information on the Credentials Committee used to credential CCHA BH providers. • *VII.CR_4-9_2020 Credentialing Policy, p. 3-4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	The following sections describe the makeup of the Credentialing Committee, how files are reviewed and approved, as well as consulting with specialist to complete review of an application. • *VIII.CR.4-9_2020 Credentialing Policy, p. 3-5, 13, 25*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A		
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days.) • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – 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	The following sections outline the time limits to credential and recredential providers under different scenarios. • *VIII.CR.4-9_2020 Credentialing Policy, p. 6-7, 11, 13, 29-31*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	The following sections outline the sanction information used during the credentialing and recredentialing process. • *VIII.CR.4-9_2020 Credentialing Policy, p. 6, 11, 31*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions.	The following sections outline what must be included in a CCHA BH network credentialing application. • *VIII.CR.4-9_2020 Credentialing Policy, p.11-13, 31*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	The following section confirms the recredentialing of CCHA BH providers every three years. • *VIII.CR.4-9_2020 Credentialing Policy, p. 7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	The following section outlines how ongoing monitoring is conducted for CCHA BH providers. • *VIII.CR.10-14_2020 Credentialing Policy, p. 7-9*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	The following sections outline the actions that may be taken against a CCHA BH provider, such as referral to the Credentials Committee for review or immediate termination, as well as the appeals process available to providers who are terminated. • *VIII.CR.10-14_2020 Credentialing Policy, p. 8-10*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm—which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	The following sections outline credentialing and recredentialing requirements for Health Delivery Organizations (HDOs) credentialed for CCHA's BH network. • *VIII.CR.10-14_2020 Credentialing Policy, p. 6-7, 20-21*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	The following sections outline the requirement for HDOs to be approved by an accrediting agency, including what accreditations are applicable for each facility type. • *VIII.CR.10-14_2020 Credentialing Policy, p. 7, 20-21*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	The following sections outline the requirements for HDOs to undergo site survey, including what site surveys may be used to meet this requirement. • *VIII.CR.10-14_2020 Credentialing Policy, p. 7, 20-21*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Element B	The following section outlines which HDOs can be credentialed for entry into CCHA's BH network. • *VIII.CR.10-14_2020 Credentialing Policy, p. 2-3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses behavioral health care providers every 36 months. NCQA MBHO CR7—Element C	The following section outlines the requirement for CCHA BH providers to be recredentialed every three years. • *VIII.CR.10-14_2020 Credentialing Policy, p. 7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/re-credentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers	The following document is a mutually agreed upon contract which outlines the duties and responsibilities of CU Medicine to credential its providers into CCHA's BH network. P. 15 outlines the NCQA elements that fall under CU Medicine's purview. • *VIII.CR.15_CU Medicine Delegated Credentialing Agreement, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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		
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	N/A- CU Medicine agreement has been in place since April 2019.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	The following sections outline the annual audit and review activities completed for CU Medicine, as well as the semi-annual report required and the timeline of submission. • *VIII.CR.15_CU Medicine Delegated Credentialing Agreement, p. 15-17*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	The following section outlines the inclusion of the review component to the CU Medicine delegated agreement. • *VIII.CR.15_CU Medicine Delegated Credentialing Agreement, p. 15-17*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.1	The following document serves as the model state-specific exhibit where Anthem enters into a subcontractor agreement for work performed for CCHA. • *IX.SD.1_CO Subcontractor Medicaid Exhibit, entire document* The following document is the overarching contract Anthem maintains with CyraCom to perform services on behalf of CCHA. • *IX.SD.1_CyraCom MSA, entire document* The following document provides a brief overview of CyraCom's responsibilities as it relates to CCHA's contractual requirement to provide translation and interpretation services to our members. • *IX.SD.1_CyraCom Contract Summary, entire document* The following contract outlines the delegated credentialing agreement CCHA maintains with CU Medicine. • *IX.SD.1_CU Medicine Delegated Credentialing Agreement, entire document* As referenced in the desk form summary, CCHA delegates care coordination activities to Accountable Care Network (ACN) Providers in both regions, and two additional entities in R7, which we refer to as "Rural	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Contractors." Materials provided include monitoring mechanisms, sample performance summaries, training materials, and meeting minutes to demonstrate oversight. Executed contracts are submitted within the Miscellaneous folder, and sample contract templates are provided for subsequent requirements. The following document outlines CCHA's policy and procedure for monitoring ACN performance, and mechanisms for oversight of contracted duties. • *IX.SD.1_ACN Monitoring and Oversight Policy, entire document* The following document outlines CCHA's policy for assessing potential ACN candidates to determine ability to fulfill contracted care coordination activities. • *IX.SD.1_ACN Assessment Policy, entire document* The following document outlines CCHA's incentive program for ACNs, and establishes performance goals and mechanisms to monitor. • *IX.SD.1_ACN Incentive Program 2020, entire document* As outlined in contracts, ACNs are required to report member-level care coordination activities to CCHA on a monthly basis. This document outlines reporting specifications.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *IX.SD.1_ACN CC Report Specs, entire document* The following document is completed by ACNs and submitted to CCHA as part of the quarterly case audit process. • *IX.SD.1_ACN Case Summary Template, entire document* The following document is used to assess trends/circumstances for members who are attributed to an ACN, but are also involved in CCHA care coordination. • *IX.SD.1_ ACN Shared Case Assessment, entire document* The following document provides summary-level case audit results for each ACN, and a sample audit template completed during each audit. • *IX.SD.1_ACN Case Audit Results, entire document* The following document provides the ACN with detailed information on earned key performance indicator and/or value based performance pool incentive dollars. • *IX.SD.1_ACN KPI VBP Summary, entire document*	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is a monthly resource produced for each ACN, which provides important announcements; an overview of the attributed population by CCHA's priority populations; and payment, operational, and performance summaries. • *IX.SD.1_ACN Monthly Overview, entire document* The following document monitors performance for the rural contractors. • *IX.SD.1_Rural Contractors Monitoring Workbook, entire document* The following documents are sample training desktop guides provided to the rural contractors to support Essette operations. • *IX.SD.1_RC Guide 1_Getting Started in Essette PM, entire document* • *IX.SD.1_RC Guide 3_PM Essette_Enrolling a Member in a Campaign, entire document* • *IX.SD.1_RC Guide 6_PM Essette_Community Resources Referred Assessment, entire document* The following documents include the referral workflow and form used by rural contractors and community entities to refer members to CCHA care coordination. • *IX.SD.1_CCHA Referral Form, R7, entire document*	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *IX.SD.1_Rural Contractor Referral Process to CCHA, entire document* The following documents are sample meeting minutes from monthly rural oversight and monitoring meetings with the rural contractors. • *IX.SD.1_AMC Meeting Minutes 09.2020, entire document* • *IX.SD.1_AMC Meeting Minutes 12.2020, entire document* • *IX.SD.1_AMC Meeting Minutes 03.2021, entire document* • *IX.SD.1_RMRH Meeting Minutes 07.2020, entire document* • *IX.SD.1_RMRH Meeting Minutes 10.2020, entire document* • *IX.SD.1_RMRH Meeting Minutes 03.2021, entire document*	
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily.	The following document is the template used for any subcontracts Anthem enters into on behalf of CCHA, which outlines the requirements of the subcontract agreement. • *IX.SD.1_CO Subcontractor Medicaid Exhibit, p. 1* The following section outlines the ability for the subcontract to be revoked if performance is not satisfactory. • *IX.SD.1_CyraCom MSA, p. 63*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: Subcontractor requirements do not apply to network provider agreements. *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	The following sections outline the responsibilities and activities CU Medicine agreed to perform, as well as terms for revocation. • *IX.SD.1_CU Medicine Delegated Credentialing Agreement, p. 1, 9* The following documents are the contract templates used for ACNs and rural contractors. • *IX.SD.2.ACN Agreement Template_2020, p. 9, 23, 34* • *IX.SD.2.CCHA Rural Contractor Service Agreement_2021, p. 5, 9*	
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	The following sections outline the subcontractor's responsibilities to follow all applicable state and federal laws and regulations. • *IX.SD.1_CO Subcontractor Medicaid Exhibit, p. 2* • *IX.SD.1_CyraCom MSA, p. 61* • *IX.SD.1_CU Medicine Delegated Credentialing Agreement, p. 10* • *IX.SD.2.ACN Agreement Template_2020, p. 15* • *IX.SD.2.CCHA Rural Contractor Service Agreement_2021, p. 10*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	The following document is the template used for any subcontracts Anthem enters into on behalf of CCHA, which outlines the requirements of the subcontractor to abide by the right for government entities to inspect and audit elements that pertain to the activities performed for CCHA's contract. • *IX.SD.1_CO Subcontractor Medicaid Exhibit, p. 2* The following section outlines CyraCom's responsibilities to make books/records available upon request. • *IX.SD.1_CyraCom MSA, p. 60* The following sections outline the subcontractor's requirements to abide by the right for government entities to inspect and audit elements that pertain to the activities performed for CCHA's contract. • *IX.SD.2.ACN Agreement Template_2020, p. 17* • *IX.SD.2.CCHA Rural Contractor Service Agreement_2021, p. 10*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* RAE Contract Amendment #4: Exhibit B-4—16.1.1	The following documents describe CCHA's Quality Plan. • *X.QAPI.1_R6_QualityImprovePlnFY20-21, entire document* • *X.QAPI.1_R7_QualityImprovePlnFY20-21, entire document* • *X.QAPI.1_R6_QualityRptFY20-21, entire document* • *X.QAPI.1_R7_QualityRptFY20-21, entire document* The following documents demonstrate CCHA's Key Performance Indicator (KPI) performance. • *X.QAPI.1_R6 KPI Dashboards, entire document* • *X.QAPI.1_R7 KPI Dashboards, entire document* The following document outlines the Peer Review process for evaluating quality incidents as part of CCHA's QAPI program. • *X.QAPI.1_Peer Review Process, entire document* The following policy outlines CCHA's grievance process for member complaints and complaints made on behalf of members. • *X.QAPI.1_Member Grievances Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following policy outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines. • *X.QAPI.1_Quality of Care Policy, entire document* The following policy describes the Critical Incidents reporting process CCHA manages under its QAPI program. • *X.QAPI.1_Critical Incidents Policy, entire document* The following sections of the BH and PH provider manuals outline CCHA's QAPI program for CCHA network providers. • *X.QAPI.1_BH Provider Manual Quality Section, p. 86* • *X.QAPI.1_PH Provider Manual, p. 21* The following document is used to assess quality and performance for behavioral health incentive program measures for behavioral health providers. • *X.QAPI.1_Behavioral Health Scorecards, entire document* The following documents outline the incentive program for physical health providers, aimed at improving the quality of care given to Medicaid members.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.1_2020 CCHA PCMP Incentive Program, entire document* • *X.QAPI.1_2020 CCHA ACN Incentive Program, entire document*	
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one for physical health and one for behavioral health.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—16.3.1, 16.3.5, 16.3.8	**R6:** The following documents are for the BH and PH PIPs and include closeout and module submissions. • *X.QAPI.2_R6_CO2019-20_BH_Depression_PIP-Close Out Submission Form, entire document* • *X.QAPI.2_R6_BH PIP-Val_Module 1_FY19-20, entire document* • *X.QAPI.2_R6_BH PIP-Val_Module 2_FY19-20, entire document* • *X.QAPI.2_R6_BH PIP-Val_Module 3_FY19-20, entire document* • *X.QAPI.2_R6_BH PIP-Val_Module 4_FY19-20, entire document* • *X.QAPI.2_R6_CO2019-20_PH_Well Care_PIP-Close-Out_Submission Form, entire document* • *X.QAPI.2_R6_PH PIP-Val_Module 1_FY19-20, entire document* • *X.QAPI.2_R6_PH PIP-Val_Module 2_FY19-20, entire document* • *X.QAPI.2_R6_PH PIP-Val_Module 3_FY19-20, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.2_R6_PH PIP-Val_Module 4_FY19-20, entire document* **R7:** The following documents are for the BH and PH PIPs and include closeout and module submissions. • *X.QAPI.2_R7_CO2019-20_BH_Depression_PIP-Close Out Submission Form, entire document* • *X.QAPI.2_R7_BH PIP-Val_Module 1_FY19-20, entire document* • *X.QAPI.2_R7_BH PIP-Val_Module 2_FY19-20, entire document* • *X.QAPI.2_R7_BH PIP-Val_Module 3_FY19-20, entire document* • *X.QAPI.2_R7_BH PIP-Val_Module 4_FY19-20, entire document* • *X.QAPI.2_R7_CO2019-20_PH_Well Care_PIP-Close-Out_Submission Form, entire document* • *X.QAPI.2_R7_PH PIP-Val_Module 1_ FY19-20, entire document* • *X.QAPI.2_R7_PH PIP-Val_Module 2_FY19-20, entire document* • *X.QAPI.2_R7_PH PIP-Val_Module 3_FY19-20, entire document* • *X.QAPI.2_R7_PH PIP-Val_Module 4_FY19-20, entire document*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract Amendment #4: Exhibit B-4—16.4.1, 16.4.4	The following policy outlines how performance data is collected and submitted to HCPF. • *X.QAPI.3_Performance Measurement Policy and Procedure, p. 1* The following document demonstrates performance data metrics using specifications provided by the state to monitor performance and implement interventions as needed in a timely manner. • *X.QAPI.3_Performance Pool Dashboards, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract Amendment #4: Exhibit B-4—16.6.1	The following documents are the Potentially Avoidable Cost Plans, the goals of which are to identify overutilization and underutilization of the appropriate levels of care. • *X.QAPI.4_R6_PACPlanFY20-21, entire document* • *X.QAPI.4_R7_PACPlanFY20-21, entire document* The following document is a sample of how CCHA reviews providers for overutilization of services. • *X.QAPI.4_CI3-HSAG Sample 12.20, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document demonstrates how CCHA members are reviewed for utilizing high rates of inpatient and intensive outpatient services to see which members (and their providers) would be most impacted by interventions to find more appropriate levels of care. • *X.QAPI.4_CO_BH_IP_ATU_PHP_IOP_ RANKED_ELIG_REGION_12112020, entire document* The following document looks at cost per CCHA members to see where intervention for more in-depth care coordination and provider outreach would be successful. • *X.QAPI.4_CO_BH_OP_MEMS_GE _700_PAID_ PER_ELIG_MONTH_12112020, entire document* The following document looks at how CCHA members are receiving their initial BH care to review for potential overutilization and underutilization trends. • *X.QAPI.4_Source of Initial Encounter Report Screenshots, entire document* The following slides demonstrate how CCHA reviews utilization of BH services on a year-to-year basis. • *X.QAPI.4_Utilization Metrics, entire document*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is an example of a Tableau dashboard used to detect underutilization. • *X.QAPI.4_Example Underutilization List, entire document* The following policy outlines the Client Over Utilization Program. • *X.QAPI.4_Client Over Utilization Program Policy, entire document*	
5. The Contractor's QAPI program includes mechanisms for identifying, investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. RAE Contract Amendment #4: Exhibit B-4—16.7.1.1, 16.7.2	The following referral form is used to notify CCHA of any alleged quality of care concerns for further review and investigation. • *X.QAPI.5_QOC Referral Form, entire document* The following document outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines. • *X.QAPI.1_Quality of Care Policy, entire document* The following document outlines the formal peer review process a provider may undergo if a quality of care issue is alleged against the provider. • *X.QAPI.1_Peer Review Process, entire document* The following documents are meeting minutes from CCHA's quarterly Quality Management Committee, which is tasked with reviewing quality of care issues and trends.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.5_R6_QMC Meeting Minutes_10-29-2020, p. 2-4* • *X.QAPI.5_R7_QMC Meeting Minutes_7-28-2020, p. 4-6* The following document is the quality improvement plan template used for a provider if deemed necessary. • *X.QAPI.5_Quality of Care Provider PIP, entire document* The following documents are meeting minutes summarizing meetings between CCHA and BH facilities to discuss quality of care complaints filed against the facility. • *X.QAPI.5_R6_Centennial Peaks QOC Trend Review Meeting Minutes_12-10-19, p. 2* • *X.QAPI.5_R7_Cedar Springs QOC Trend Review Meeting Minutes_2-13-20, p. 2-3* • *X.QAPI.5_R7_Peak View Meeting Minutes_10-21-19, p. 2* The following deliverables are provided to HCPF on a quarterly basis to reflect CCHA's monitoring and investigation of quality of care concerns received during the reporting period, as well as identifying and tracking trends. • *X.QAPI.5_ R6_QMC QOC Summary Report_ SFY 20-21_Q1, entire document*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.5_R7 QMC QOC Summary Report_SFY 20-21_Q1, entire document*	
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* RAE Contract Amendment #4: Exhibit B-4—16.2.1.4 10 C.C.R. 2505-10, 8.205.9	The following policy outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines. • *X.QAPI.1_Quality of Care Policy, entire document* The following policy outlines how members with special health care needs, as defined by the State, are provided continuity of care and care coordination referrals to maintain appropriate levels of care. • *X.QAPI.6_Transition of Care Policy, entire document* The following policy describes the Critical Incidents reporting process CCHA manages under its QAPI program for CCHA members with special health care needs receiving Home and Community Based Services (HCBS) when enrolled with CCHA. • *X.QAPI.1_Critical Incidents Policy, entire document* The following document provides an overview of CCHA's care coordination model, which includes special populations. • *X.QAPI.6_CCHA CC Model, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is a case review template used for weekly meetings with HCPF to review escalated cases to collaborate and ensure quality, appropriateness, and coordination of care. • *X.QAPI.6_Escalated Case Template For HCPF Case Reviews, entire document* CCHA has executed agreements with the Single Entry Points (SEPs) and Community Centered Boards (CCBs), in its regions. The following documents are examples of Memorandums of Understanding and workflows with the SEPs and CCBs, which include mechanisms to assess quality and appropriateness of care for the special populations these community entities serve. **R6:** • *X.QAPI.6_ACMI- MOU, entire document* • *X.QAPI.6_ACMI Workflow, entire document* • *X.QAPI.6_Imagine! MOU, entire document* • *X.QAPI.6_Imagine!- Workflow, entire document* **R7:** • *X.QAPI.6_TRE MOU, entire document* • *X.QAPI.6_TRE Workflow, entire document* The following document is a template used for Complex Case Review meetings with the SEPs and CCBs in both regions.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.6_Complex Case Review Referral Form, entire document* The following documents provide an overview of the mechanisms of evaluation used to assess the care provided to Medicaid members who have contact with the Colorado Department of Corrections (DOC). • *X.QAPI.6_DOC Dashboards, entire document* • *X.QAPI.6_DOC BH Measure Workflow, entire document* • *X.QAPI.6_DOC RAE Workflow, entire document* In order for Medicaid members or other stakeholders to be able to submit quality of care concerns at any point of contact with CCHA, CCHA trains its member-facing staff annually on the quality of care and grievance processes. The following documents are training materials used and attestations of training completion. • *X.QAPI.6_Grievance and QOC Training Slides, entire document* • *X.QAPI.6_MSS Attestation_ Grievance and QOC Training, entire document* • *X.QAPI.6_R6 CC Attestation_Grievance and QOC Training, entire document* • *X.QAPI.6_R7 CC Attestation_Grievance and QOC Training, entire document* • *X.QAPI.6_BH CC Attestation_Grievance and QOC Training, entire document*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.6_UM Mrg Attestation_Grievance and QOC Training, entire document* The following document is a provider newsletter where CCHA notified the provider network of a training opportunity on disability culturally competent care, to ensure our provider network can provide appropriate care to special populations. • *X.QAPI.6_Provider Newsletter December 2020-Etiquette Tips, p 3*	
7. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • CAHPS survey • ECHO survey RAE Contract Amendment #4: Exhibit B-4—16.5.1-2, 16.5.6	The following document is a summary of a member survey campaign. • *X.QAPI.7_Member Survey Summary 2021, entire document* CCHA's Member Advisory Committee (MAC) engages Medicaid members to provide feedback on its program. The following documents provide information used to recruit members. • *X.QAPI.7_MAC Information, entire document* • *X.QAPI.7_MAC Recruitment Interest Form, entire document* Members provide feedback both anecdotally during MAC meetings, and through surveys sent via email, mail or over the phone. The following documents include examples of member feedback collected.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.7_MAC Minutes Nov 2020, entire document* • *X.QAPI.7_MAC Grievance Letter Feedback, entire document* The following reports track grievances and appeals filed during the reporting period. All member complaints are tracked, including those related to access to care. • *X.QAPI.7_R6_GrieveAppealRpt_Q2FY20-21, entire document* • *X.QAPI.7_R7_GrieveAppealRpt_Q2_FY20-21, entire document* The following parts of the Grievance and Appeal report provide a narrative including more information for the grievances and appeals filed during the report period, including any identifiable trends. • *X.QAPI.7_Grievance and Appeals Report Part II RAE 6 Qtr 2 2020-2021, entire document* • *X.QAPI.7_Grievance and Appeals Report Part II RAE 7 Qtr 2 2020-2021, entire document* The following policy outlines CCHA's grievance process for member complaints and complaints made on behalf of members, including complaints related to access issues. • *X.QAPI.1_Member Grievances Policy, entire document*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines call center quality metrics. • *X.QAPI.7_Call Center Dashboard, entire document* The following annual quality reports include a section outlining information on member experience of care, including CAHPS and ECHO survey results, and grievances. • *X.QAPI.1_R6_QualityRptFY20-21, p. 30-39* • *X.QAPI.1_R7_QualityRptFY20-21, p. 30-38* The following document outlines CAHPS and ECHO results and the interventions made with appropriate providers as a result. • *X.QAPI.7_CAHPS & ECHO Results and Interventions, entire document*	
8. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract Amendment #4: Exhibit B-4—16.2.5	The following documents outline CCHA's process for evaluating its Quality program. • *X.QAPI.1_R6_QualityRptFY20-21, entire document* • *X.QAPI.1_R7_QualityRptFY20-21, entire document* The following Program Improvement Advisory Committee (PIAC) minutes demonstrate that CCHA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reports out on and seeks feedback regarding its KPI performance quarterly with its stakeholders. • *X.QAPI.8_R6 PIAC Minutes 9.2020, p. 4* • *X.QAPI.8_R7 PIAC Minutes 9.2020, p. 3*	
9. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract Amendment #4: Exhibit B-4—14.8.8.1-3	RAE contract—practice guidelines apply to BH services The following document outlines CCHA's Clinical Practice Guidelines for BH conditions. • *X.QAPI.9_Clinical Practice Guidelines, entire document* For utilization management purposes, CCHA adopts clinical criteria to apply to BH UM decisions. The following policy outlines how clinical criteria is applied to UM decisions, as well as how the criteria is adopted. • *X.QAPI.9_Clinical Criteria for UM Decisions Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract Amendment #4: Exhibit B-4—14.8.8	The following policy outlines how clinical criteria is applied to UM decisions, as well as how the criteria is shared with providers upon request. • *X.QAPI.9_Clinical Criteria for UM Decisions Policy, p. 4* The following section of the member notice of adverse benefit determination informs members of their right to request and receive the information used to make a service determination, including applicable clinical guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *X.QAPI.10_CO NoABD, p. 4-5* The following section of the policy outlines the various ways information can be shared with a member. • *X.QAPI.10_Member and Provider Website and Communication Policy, p. 2* The Clinical Practice Guidelines are available on the CCHA website for any provider or member to reference. • *X.QAPI.9_Clinical Practice Guidelines, entire document*	
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract Amendment #4: None	The following policy outlines the process CCHA uses to apply clinical criteria to utilization management decisions to ensure consistency with the guidelines and across utilization management decisions. • *X.QAPI.9_Clinical Criteria for UM Decisions Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract Amendment #4: Exhibit B-4—15.1.1	The following document is an overview of the Management Information System Anthem utilizes on CCHA's behalf for behavioral health services. • *X.QAPI.12_Anthem_MIS_Overview, entire document* The following document outlines CCHA's data validation process. • *X.QAPI.12_CCHA Data Flow, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B—15.1.1, 8.1	Note: For RAEs, these elements apply only to BH services. The following section outlines the areas that the Anthem MIS manages, including claims, case management, provider data, credentialing, enrollment, encounters, grievances and appeals, and program integrity. • *X.QAPI.12_Anthem_MIS_Overview, p. 1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.2	Note: for RAEs, claims/encounter systems relate only to BH capitated services. The following diagram demonstrates how encounters are managed within Anthem's system and relayed to the State. • *X.QAPI.12_Anthem_MIS_Overview, p. 3* The following policy outlines the process used to submit CCHA BH encounters to the State. • *X.QAPI.14_Colorado Encounters Process Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.1, 15.2.2.3.2	The following section outlines which member and provider behavioral health data is maintained on behalf of CCHA. • *X.QAPI.12_Anthem_MIS_Overview, p. 1-2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following policy outlines the process for reviewing, validating, and submitting encounters to the State. • *X.QAPI.14_Colorado Encounters Process Policy, entire document* The following templates are examples of how CCHA collects member data. • *X.QAPI.15_Intake Assessment, entire document* • *X.QAPI.15_Adult HNA, entire document* The following templates collect physical health provider data, both initially when requesting to join the network, and as part of the ongoing review process. • *X.QAPI.15_New Practice Application Form, entire document* • *X.QAPI.15_New Provider Application Form, entire document* • *X.QAPI.15_Quality Office Systems Review, entire document*	
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information	The following policy outlines the process used to process claims and validate encounters. • *X.QAPI.14_Colorado Encounters Process Policy, p. 2* The following documents outline the data collected and the processes by which it is verified for physical health providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.1, 15.2.2.3.5.1	• *X.QAPI.15_New Practice Application Form, entire document* • *X.QAPI.15_New Provider Application Form, entire document* • *X.QAPI.15_Quality Office Systems Review, entire document* • *X.QAPI.16_Request to Join Provider Network - PCMP Policy, entire document* • *X.QAPI.16_PCMP License Screening Process, entire document* • *X.QAPI.16_K-Checks User Guide, entire document* The following document outlines CCHA's data validation process. • *X.QAPI.12_CCHA Data Flow, entire document* The following document outlines the data reporting specifications for member level reports reported to CCHA by the ACN. • *X.QAPI.16_ACN CC Report Specs, entire document* The following document outlines CCHA's policy and procedure for collecting and submitting performance data to the State. • *X.QAPI.16_Performance Measurement Policy and Procedure, entire document*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract Amendment #4: Exhibit B—4-15.2.2.3.2-3, 15.2.2.3.5	The following document describes the requirements for CCHA's BH encounter system, including format and submission timeline after claim adjudication. • *X.QAPI.17_CCHA_Encounter Data Mgmt System, p. 3* The following policy outlines the process used to submit CCHA BH encounters to the State. • *X.QAPI.14_Colorado Encounters Process Policy, entire document*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Colorado Community Health Alliance Regions 6 and 7

Review Period:	January 1 through December 31, 2020
Date of Review:	May 4, 2021
Reviewer:	Erika Bowman, BA, CPC
Health Plan Participant:	Abigail Roa, Rebekah Hensley-Martin, and Heather Pickell

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: ***** Credentialing Date: 01/14/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: ***** Credentialing Date: 03/20/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: ***** Credentialing Date: 06/05/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: ***** Credentialing Date: 08/20/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: ***** Credentialing Date: 10/09/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Colorado Community Health Alliance Regions 6 and 7

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: ***** Credentialing Date: 01/08/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: ***** Credentialing Date: 02/22/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: ***** Credentialing Date: 04/16/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: ***** Credentialing Date: 06/08/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: ***** Credentialing Date: 08/29/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**3**	**10**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**3**	**10**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**86**
Total Number of Compliant Elements	**86**
Overall Percentage Compliant	**100%**

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

Instructions:

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

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Colorado Community Health Alliance Regions 6 and 7

Review Period:	January 1 through December 31, 2020
Date of Review:	May 4, 2021
Reviewer:	Erika Bowman, BA, CPC
Health Plan Participant:	Abigail Roa, Rebekah Hensley-Martin, and Heather Pickell

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: ***** Current Recredentialing Date: 01/08/20 Prior Credentialing or Recredentialing Date: 03/24/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: ***** Current Recredentialing Date: 02/13/20 Prior Credentialing or Recredentialing Date: 05/11/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: ***** Current Recredentialing Date: 05/05/20 Prior Credentialing or Recredentialing Date: 07/03/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: ***** Current Recredentialing Date: 06/04/20 Prior Credentialing or Recredentialing Date: 08/07/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #5 Provider ID: ***** Current Recredentialing Date: 08/07/20 Prior Credentialing or Recredentialing Date: 01/27/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: ***** Current Recredentialing Date: 02/18/20 Prior Credentialing or Recredentialing Date: 04/14/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: ***** Current Recredentialing Date: 04/25/20 Prior Credentialing or Recredentialing Date: 07/20/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: ***** Current Recredentialing Date: 05/15/20 Prior Credentialing or Recredentialing Date: 07/24/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: ***** Current Recredentialing Date: 07/31/20 Prior Credentialing or Recredentialing Date: 09/13/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: ***** Current Recredentialing Date: 09/24/20 Prior Credentialing or Recredentialing Date: 12/27/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**10**	**2**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**2**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**75**
Total Number of Compliant Elements	**75**
Overall Percentage Compliant	**100%**

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

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)

3. Applicable if the practitioner states on the application that he or she is board certified

4. Malpractice settlements in most recent five years

5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

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

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

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **CCHA R7**.

Table C-1—HSAG Reviewers and CCHA R7 and Department Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager III
Erica Arnold-Miller	Project Manager II
CCHA R7 Participants	**Title**
Abigail Roa	Compliance Director, Anthem
Amie Staudenmaier	Director, Organizational Development, PHP
Amy Yutzy	Director, Medicaid Programs, R7, CCHA
Andrea Kedley	Community Liaison, CCHA
Andrea Skubal	Accountable Care Network Program Manager, CCHA
Camila Joao	Clinical Quality Program Manager, Anthem
Cindi Terra	Manager, Quality & Practice Transformation, CCHA
Clara Cabanis	Senior Manager, Strategy & Performance, CCHA
Colleen Daywalt	Manager, Marketing & Communications, CCHA
Colleen McKinney	Planning & Performance Director, Anthem
Deb Munley	Senior Vice President, Quality and Clinical Programs, CCHA
Diana Highsmith	Business Information Consultant, Anthem
Diane Seifert	Network Manager, R7, CCHA
Erica Douglas	Business Information Consultant, Anthem
Erica Kloehn	Director, Network Management, Anthem
Gina Wendling	Director, Medicaid State Operations, Anthem
Hanna Thomas	Director, Medicaid Programs, R6, CCHA
Heather Pickell	Lead Credentialing Coordinator, Anthem
Jackie Ferguson	Director, Provider Experience, Anthem
Janel Glover	Business Change Manager, Anthem
Janelle Shields	Customer Care Representative, Anthem
Janet Bonham	Investigations Manager, Special Investigations Unit, Anthem
Jason Eberle	Business Change Manager, Anthem
Josie Dostie	Senior Network Manager, R6, CCHA

CCHA R7 Participants	Title
Kathryn Morrison	Director, Quality Improvement, Anthem
Katie Mortenson	Quality Program Manager, CCHA
Kelli Gill	Director, Behavioral Health Services, Anthem
Ken Nielsen	President, CCHA
Krista Newton	Director, CCHA Operations, CCHA
Kristen Mader	Provider Data Analyst Sr., Anthem
LaShonda Mazique	Program Integrity Manager, Anthem
Latisha Greene	Director, Financial Operations, Anthem
Leigh-Ann Cole	Clinical Quality Manager, Anthem
Leigh-Ann Rocha	Manager, Regulatory & Contracting, PHP
Lina Quintero	Director, Grievance & Appeals, Anthem
Leslie Carpenter	Manager, Premium Reconciliation, Anthem
Lizbeth Villaruz	Internal Audit Manager, Anthem
Mandy Plate	Compliance Program Manager, Physician Health Partners
Megan Lujan	Administrative Assistant, CCHA
Monique Ellis	Clinical Compliance Consultant, Anthem
Nancy Sare	Business Change Manager, Anthem
Pamela Tanis-Hickmon	Compliance Manager, Anthem
Patrick Fox, MD	President, Anthem
Rachel Sundermeyer	Finance Manager, Anthem
Rebekah Hensley-Martin	Credentialing Manager, Anthem
Rodney Mack	Business Change Manager, Anthem
Sabrina Voltaggio	Project Coordinator, CCHA
Sophie Thomas	Medicaid Program Manager, CCHA
Teresa Butterfield	Regulatory Compliance Consultant, Anthem
Terri Piechocki	Government Business Division, Account Management, Anthem
Tom Fish	Manager, Operations, Provider Education & Program Integrity, Anthem
Tony Olimpio	Manager, Member Support Services, CCHA
Verchelle Parris	Business Change Manager, Anthem
Zula Solomon	Director, Quality & Clinical Programs, CCHA

Department Observers	Title
Lauren Staley	ACC Program Specialist
Milena Guajardo	HPO Program Specialist
Russell Kennedy	Quality and Compliance Specialist

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

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

Table D-1—Corrective Action Plan Process

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

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

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

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across RAEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided RAEs with proposed site review dates, group technical assistance and training, as needed. • HSAG confirmed a primary RAE contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and site review activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The RAE also submitted a list of all provider credentialing records and all provider recredentialing records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). The RAE submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review.

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