COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2021–2022 Site Review Report

for

Colorado Community Health Alliance

Region 6

June 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

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 providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCM entities and PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2021–2022 site review activities for **Colorado Community Health Alliance** (**CCHA**) Region 6. For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2021–2022 and the required template for doing so. Appendix D contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: May 2, 2022.

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	9	1	0	0	90%
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
V. Member Information Requirements	18	15	13	2	0	3	87%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**38**	**34**	**4**	**0**	**3**	**89%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

CCHA provided care coordination and continuity of care for members in Region 6, and submitted policies, procedures, systemwide processes, an electronic care coordination tool, guides, manuals, and other materials that outlined a range of deliberate care coordination programs and activities to support members' healthcare needs. **CCHA** Region 6's organizational structure included combining comprehensive resources from Anthem, Physician Health Partners, Centura Health, and Primary Physician Partners to create a model of care that combined services for behavioral health and physical health. Members received care coordination and continuity of care through delegated providers making up the Accountable Care Network (ACN), which represented five provider groups: Clinica Campesina Family Health Services, Every Child Pediatrics, Peak Pediatrics, Salud Family Health Centers, and STRIDE Community Health Centers. **CCHA** Region 6 serves over 190,000 members, and ACN providers engaged in care coordination services with 34 percent of those members representing Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson counties. Local service providers are connected to ACN providers to further support each member's physical and behavioral health needs. For members with more complex health needs, **CCHA** intervened and helped the member receive appropriate care and services. **CCHA** took accountability over the ACN providers to assess whether members were receiving appropriate care when the ACN providers did not have adequate resources and supported the care coordination needs of members through **CCHA**'s vast organizational resources.

CCHA's clinical care coordination team included diverse staff members ranging from registered nurses, social workers, behavioral health care coordinators, care navigators, and outreach care/peer support specialists. The clinical care coordination team worked with Member Support Services (MSS) to engage with members and deliver a "whole-person" care approach. While care coordination was available to all **CCHA** members, **CCHA** placed emphasis on outreaching members identified through the *Health Needs Survey* (HNS) and risk stratification as high risk, high need, and high cost to engage in active care management.

CCHA used the results of the HNS, admission, discharge, and transfer (ADT) feeds, condition management lists, and other outreach information to identify members who may benefit from care coordination services. **CCHA** processed a weekly data transfer from the Department containing HNSs and conducted outreach to members who were identified as needing care coordination. **CCHA** MSS attempted to contact the member through live outreach three times. Once member contact was made, the member was informed about **CCHA** and resources available, and **CCHA** MSS attempted to conduct additional assessments, such as **CCHA**'s *Community Resources Preferred* or *Diabetes Assessment*, to build a care plan.

Referrals into care coordination included identification through claims data, referrals from providers, hospitals, community partners, the Department, and self-referrals. Members identified as needing ongoing support were then assigned to a specialized care program such as: Complex Care Coordination, Adult Integrated Systems, Chronic Disease Management, Maternity, Pediatrics and Foster Care, Justice

Involved, Transitions of Care, Behavioral Health Transitions of Care, and Specialized Transitions of Care (STOC). MSS and care coordinators outreached the member through outbound calls to help determine care coordination needs. **CCHA** discussed oversight of MSS calls and utilized the *CCHA Call Monitoring Form* to assess the quality of calls and to ensure MSS staff adequately responded to the member's needs.

Staff members described a provider tier model, differences within each tier, and required expectations outlined in primary care medical provider (PCMP) agreements. Tier 1 providers provided basic PCMP services to the member. Tier 2 providers were required to have a comprehensive care coordination model and have at least one condition management program available to their attributed members. Tier 3 providers included the five ACNs that used a community-based care coordination model and offered at least two condition management programs to the member. The *PCMP Agreement* included reporting requirements for Tier 2 and Tier 3 providers. To assist the tiered provider groups, **CCHA** provided added support to members with complex healthcare needs. Additionally, **CCHA** intervened when gaps in care for the member were identified through complex case reviews, auditing of the providers' electronic health records (EHRs), and regularly held quality meetings.

CCHA provided an overview of procedures for analyzing the member attribution list. The practice transformation team manager analyzed the Department's attribution list monthly to identify any significant gains or losses compared to the previous month's roster. MSS and care coordination staff members provided support if member reattribution needed to take place. Staff members described monthly meetings with the enrollment broker and direct communication lines to ensure warm handoffs to assist members in submitting attribution change requests. **CCHA** attempted to identify barriers to care the member possibly faced such as distance, dissatisfaction of service, or cultural considerations.

Staff members described close working relationships with community mental health centers (CMHCs) and regular data exchanges that included a chronic index scoring list and daily census. **CCHA** care coordinators and staff members at the CMHCs engaged in regular meetings to discuss cases and discharge follow-ups. **CCHA** utilization management (UM) and care coordination staff members worked together through daily integrated rounds to discuss complex cases, provide feedback, and share additional information. As an added resource to view member information, care coordinators also had access to UM's documentation systems, Facets and Anthem 360.

Staff members provided a live demonstration of the comprehensive electronic care coordination tool, Essette. Essette collected and aggregated all required data, including the member's age, gender identity, race/ethnicity, care coordinator information, care coordination notes, and information that can aid in creation and monitoring of the care plan (e.g., clinical history, social support, community resources).

Numerous policies and procedures described **CCHA**'s effort to reduce duplication of activities by performing complex case reviews, sharing member care plans, and communicating with the lead care coordinator and providers involved in the member's care. **CCHA** further detailed the various secure methods of communication between providers and **CCHA** through Essette, email, telephonic communications, fax, and Secure File Transfer Protocol (SFTP) site. The *Behavioral Health Provider Agreement*, *PCMP Agreement*, and provider manual outlined the expectations for maintaining, sharing,

and protecting the member health records in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Summary of Findings Resulting in Opportunities for Improvement

While **CCHA**'s policies, procedures, and program descriptions addressed the various pathways a member may enter care coordination and supported the "no wrong door" referral process, the numerous avenues of entry resulted in a variety of possible responses to the referral and methods of inputting referral details into **CCHA**'s system. The *CMHC Data Sharing Workflow* outlined when high-risk members, such as those identified through behavioral health and substance use disorder authorization requests, are compiled and shared with CMHCs. However, **CCHA** staff members could not confirm the expected follow-up or outreach methods used by these entities to outreach these high-risk members. Additionally, UM staff members stated referrals after a denial of services occurred on a case-by-case basis but did not reference specific details/thresholds/rubrics considered to refer newly identified members into care coordination. The Essette system included a mechanism to inform care coordinators about updates for members already engaged in care coordination. HSAG recommends **CCHA** enhance procedures as well as create a workflow to better detail how **CCHA** processes and prioritizes referrals and/or service denials (in which a member may need additional coordination) to ensure follow-ups when needed.

Summary of Required Actions

CCHA documents clearly detailed internal **CCHA** care coordination procedures, program descriptions that contained outreach and monitoring expectations, and methods of communicating with entities involved in member care. However, a significant percentage of member care coordination occurred through ACN delegates. Delegated care coordination activities ranged from three tiers of care: 1) basic medical home models, 2) condition management, and 3) fully delegated to ACN. Although the PCMP agreements contained a general statement about referral and collaboration expectations, the agreements did not detail expected mechanisms for the PCMP to inform **CCHA** about high-risk members or members for whom additional support is needed due to the PCMP not offering specific condition management programs. Staff member interviews indicated the PCMPs may communicate with **CCHA** through email or may meet monthly or quarterly with **CCHA** care coordination staff to discuss high-risk members. However, documentation did not clearly describe PCMP expectations regarding referral procedures or timeliness. **CCHA** must strengthen applicable documents and create a more detailed procedure that outlines referral procedures and timeliness expectations and how **CCHA** ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP tier or condition management capabilities.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

CCHA communicates member rights through the *Member Rights and Responsibilities* policy, *Member Grievances* policy, *Privacy* policy, *Member and Provider Materials and Website* policy, *ADA Compliance for Network Providers* policy, provider manual, provider newsletters, member handbook, Frequently Asked Questions (FAQ) webpage, and member benefits and services webpage. In addition, **CCHA** submitted a *Member Rights and Advance Directive Training Attestation* that demonstrates **CCHA**'s efforts in ensuring that members' rights are upheld by staff members. **CCHA**'s policies described processes for ensuring compliance with applicable State and federal laws pertaining to member rights, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act (ADA), and Section 1557 of the Patient Protection and Affordable Care Act.

During the interview, staff members discussed that the quality department is responsible for creating and maintaining **CCHA**'s policies, including those relating to member rights. In addition, the care coordination, communications, compliance, and grievance departments worked collaboratively to ensure members' rights are protected. The Member Advisory Council (MAC) met quarterly, and if needed, member rights topics could be addressed at these meetings. Since the pandemic, these meetings pivoted to virtual engagements. Staff members discussed how **CCHA** receives feedback and suggestions from members through the MAC, online surveys, and the *Contact Us* form on the **CCHA** website. **CCHA** required staff members to complete privacy trainings on topics such as ethics, compliance, privacy, information security, and physical security and submitted evidence regarding these trainings.

The *Member and Provider Materials and Website* policy described how **CCHA** ensures that members receive information in accordance with information requirements. The *Individual Access to Designated Record Set* policy discussed procedures for supporting and assisting members in obtaining their designated record set; the policy also discussed that members could make such requests in writing on the **CCHA** website and through phone calls. **CCHA** provided the *Member Communication Plan* policy, which described processes to foster respectful interactions and provide adequate choice of treatment modalities in accordance with the member's identified needs and available resources. The *Privacy* policy stated that "all **CCHA** employees are required to sign an employee confidentiality agreement." In addition, the policy discussed that employees, temporary workers, providers, vendors, subcontractors, consultants, and anyone acting on behalf of the company are expected to follow federal and State laws, rules, regulations, and contractual requirements for maintaining the confidentiality of patient and corporate information.

CCHA provided various documents to show its efforts regarding educating members and their families, the community, staff members, and providers regarding advance directives. The *Behavioral Health Provider Manual*, *Physical Health Provider Manual*, and December 2021 provider newsletter included sections about advance directives and how providers can support members regarding them. **CCHA**

submitted the *PIAC Update Email March 2022* document that demonstrated how **CCHA** educates community partners, providers, and members regarding advance directives and provides resources and information about advance care planning.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

The *Member and Provider Materials and Website* policy discussed **CCHA**'s processes for ensuring that member informational materials comply with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's *Web Content Accessibility Guidelines*. The Health First Colorado welcome letter was mailed to members upon enrollment. In addition, members may receive other informational materials from care coordination, community partners, member supports services, enrollment brokers, or the Department of Human Services (DHS) through modes such as text messaging, outbound calls, social media, letters, enrollment card, and web-based educational materials. **CCHA** used the Flesch-Kincaid scale to ensure readability of portable document formats (PDFs) and the Userway tool to ensure accessibility for the website. **CCHA** consulted with the MAC to ensure member materials critical to obtaining services are member tested and that communication is understandable and member friendly.

CCHA used various avenues to help members understand the requirements and benefits of their plan. Members could refer to the website and *Map to Medicaid* guide for more information about benefits. **CCHA** provided a *Program Description for Member Support Services* and a *Member Support Services* policy that described the role of MSS in helping members understand their benefits.

The *Member and Provider Materials and Website* policy stated that "**CCHA** makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services." Staff members discussed that **CCHA** uses translation services, language lines, and a translation vendor to ensure the availability of materials and accessibility of services. Staff members stated that interpreters answer the language line within seconds. In addition to these vendors, **CCHA** also had an American Sign Language (ASL) vendor that providers often utilized to connect members to ASL services. Information about language assistance services, including

written translations, oral interpretation, and auxiliary aids/services provided at no cost to the member, was seen on the nondiscrimination notice, **CCHA** FAQ webpage, and on many of the informational materials. **CCHA** reported occasionally using printing and mailing vendors.

All critical informational materials were available in both English and Spanish. Both the member and provider pages on the **CCHA** website stated that electronic information is available in paper form without charge upon request within five business days. This statement was placed in prominent locations across its website where critical materials are available.

CCHA's provider directory was easy to navigate and available in a machine-readable format once exported. The online provider directory included a comprehensive list of ADA accommodations and enabled members to search and select providers using different criteria such as the provider's name and group affiliation, street address(es), telephone number(s), website Uniform Resource Locator (URL), specialty, and whether the provider will accept new enrollees.

CCHA leveraged Program Improvement Advisory Committee (PIAC) meetings to receive feedback on incentive programs and the distribution of funds and provides information about provider incentive programs through the FAQ portion of the website, which routes the member to contact MSS.

Summary of Findings Resulting in Opportunities for Improvement

Regarding making a good faith effort to send a written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, the *PCMP Network Disaffiliation Procedure* policy stated that "the network manager or ACN program manager will draft a practice closing/termination letter and send to communications for review. If a roster is greater than 500 members, the mailing will be outsourced to the printer for bulk mail; if it is less than 500 members, the Network Manager or ACN Program Manager will work with internal staff to send out the mailing." Staff members discussed that in such instances, **CCHA** sends the letters to members using First-Class Mail and provided supporting evidence that outlined this process. However, the process did not show monitoring mechanisms to ensure that members received the notice within the time limits. HSAG recommends that **CCHA** develop a mechanism to track and ensure the timeliness of these written notices.

Summary of Required Actions

The *Member and Provider Materials and Website* policy described procedures for ensuring that member informational materials contain taglines in large print (conspicuously visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation, the toll-free and TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) customer service numbers, and availability of materials in alternative formats. However, some critical member materials did not include all required components of a tagline, such as the *Member Complaint Resolution Letter*; *Notice of Adverse Benefit Determination*; *Map to Medicaid*; *Maternity*

Brochure; *Foster Care Children & Caregiver Resources Member Guide Insert*; *Care Coordination Benefits Member Insert*; *Well Child Insert*; and *Early and Periodic Screening, Diagnostic, and Treatment* (EPSDT) flyer. Materials that are critical to obtaining services must include taglines, and the materials on this list contained critical information about **CCHA** members accessing care and understanding core programs that **CCHA** offers. **CCHA** must revise critical member materials to include all required components of a tagline. HSAG recommends **CCHA** standardize taglines across all critical informational materials.

Staff members discussed the turnaround timelines for ad hoc requests for printed materials, provided screenshots of the Essette system where ad hoc requests could be documented, and provided email evidence that demonstrated an example of receiving and responding to such requests. For this example, staff mailed the requested materials within two days. However, the screenshot in Essette submitted as evidence stated that it "will take five to seven business days for the member to receive" the informational materials, further indicating a timely ad hoc printing and mailing process is not clear to staff members or documented in procedures. **CCHA** did not provide any supporting document regarding monitoring that ad hoc requests are printed and mailed to members within five business days. **CCHA** must develop a mechanism to ensure that, upon request, members are provided with printed materials within five business days and at no cost.

CCHA used the Department's welcome letter and the *Health First Colorado Member Handbook* to inform newly enrolled members about services. HSAG observed that although the welcome letter points members to the *Health First Colorado Member Handbook*, which includes almost all required information, the welcome letter distributed by the Department during calendar year (CY) 2021 did not contain **CCHA**'s website address and neither did the *Health First Colorado Member Handbook*. Based on additional evidence in the form of email communications between **CCHA** and the Department, **CCHA** was under the impression that the welcome letter used throughout FY 2021–2022 contained the website address details for each managed care entity. Based on this information, the requirement is considered met. The Department reported that an updated letter that will include the RAE's website address is estimated to go into production in July 2022; therefore, no required action associated with this finding is needed.

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

Summary of Strengths and Findings as Evidence of Compliance

EPSDT-eligible members received outreach through either live or automated telephone calls, text messages, and in some cases through mailed materials to ensure a combination of approaches. For certain at-risk groups, such as pregnant minors, **CCHA** further tailored the outreach to include live telephone calls.

Educational materials for members, providers, and staff followed the American Academy of Pediatrics *Bright Futures Guidelines* periodicity schedule for preventive healthcare, informed members that **CCHA** is available to arrange appointments, and offered assistance to obtain transportation services. In addition to non-emergency medical transportation, which was offered by IntelliRide, **CCHA** staff members described working occasionally with Lyft for immediate and unique transportation needs and included a *Lyft Assessment* in Essette.

CCHA community liaisons worked closely with DHS staff members to provide information to members newly engaged in foster care, child welfare, and adoption programs. **CCHA** community liaisons attended monthly meetings to educate DHS case workers about benefits, including DHS new hires watching training webinars and developing educational materials for adoptive parents and foster parents. **CCHA** staff members noted success with Boulder County's robust case management system and challenges with smaller counties where resources and staffing turnover had impacted county staffing and required **CCHA** to step in for additional support.

Providers received information about EPSDT through the provider manual, newsletters, and recorded trainings available on the **CCHA** website. **CCHA** staff members participated in onboarding training and care coordination department staff members were required to participate in additional trainings such as the recorded EPSDT webinar.

CCHA implemented policies and procedures to provide or arrange for medically necessary services, submitted a variety of assessments, and communicated EPSDT expectations to providers, including documenting screening and results in medical records and regular audits conducted by **CCHA** staff members. Numerous program descriptions submitted by **CCHA** clearly outlined risk stratification, referral procedures and external partners, care plan details, monitoring, ongoing outreach timelines, and details about community resources. Each program description described measures of success and ways **CCHA** monitored program outcomes.

Summary of Findings Resulting in Opportunities for Improvement

CCHA's website contained a few minor errors on the FAQ webpage such as broken links to the Department's EPSDT information and some EPSDT informational details that included federal citations that were not member friendly. HSAG recommends ensuring the accuracy and readability of website information prior to posting and reviewing links regularly as part of a best practice approach to maintaining EPSDT informational materials.

Submitted meeting minutes indicated a few examples in which providers expressed concern when services for members were either not available or were denied and lower-level care was approved. Additionally, **CCHA** submitted limited documentation to verify how EPSDT considerations are processed within the UM department. HSAG recommends that **CCHA** 1) enhance documentation and communication procedures with providers regarding which services are available in and out of state and collaborate on care plans when waiting for the level of service required, and 2) expand UM policies and procedures to better document how EPSDT considerations are included in the UM review process and communicated to members, care coordinators, and providers as appropriate.

Summary of Required Actions

The *Early and Periodic Screening, Diagnostic and Treatment Colorado* policy described that outreach to foster care members occurred through the DHS case workers; however, **CCHA** reported issues with identifying this member population in two out of the four quarters in the review period, CY 2021. During the interview, **CCHA** could not confirm 1) the process in which DHS outreached members and did not have a monitoring mechanism to ensure outreach occurred, or 2) a long-term resolution for the foster care data issue. **CCHA** must develop a process to ensure access to foster data and outreach to newly eligible foster children is completed within 60 days of identification, either by DHS or **CCHA**.

Additionally, **CCHA** did not outreach members who had not utilized services in the previous 12 months during three of the four quarters. Then in the last quarter of CY 2021, **CCHA** completed outreach to non-utilizers but noted an issue with data sorting procedures, which lead to inadvertently outreaching members who had utilized services in the previous 12-month period. Due to **CCHA** implementing the outreach procedures for non-utilizers at the end of CY 2021, no required action is necessary. However, HSAG recommends revisiting quality assurance procedures regarding this data set.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

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

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2021, through December 31, 2021. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of documents and materials requested during the site review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix D contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **CCHA** until it completed each of the required actions from the FY 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. **CCHA** did not have any findings resulting in required actions.

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit*, the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs.	*All documents in every standard apply to both regions unless explicitly noted.* *The following document outlines CCHA's policy related to care coordination to ensure consistent coordination of care for all members and is supported by the care coordination procedures outlined in the program descriptions below.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pgs. 1, 2, 3 *CCHA's Care Coordination Policy and program descriptions outline specific activities focused on acute, complex, and high-risk patients and ensures that care coordination is accessible, provided at the point of care, and respects member preferences. To reduce duplication and address gaps, CCHA has also defined specific partnerships and co-locations to support care coordinators in collaborating with other service providers.* • III.CCC.1_CCHA Program Description - Adult Integrated Systems, entire document • III.CCC.1_CCHA Program Description - Behavioral Health Transitions of Care, entire document • III.CCC.1_CCHA Program Description - Chronic Disease Management, entire document • III.CCC.1_CCHA Program Description - Complex Care Coordination, entire document	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b) Contract Amendment 7: Exhibit B6—11.3.1, 11.3.7	• III.CCC.1_CCHA Program Description - Justice Involved, entire document • III.CCC.1_CCHA Program Description - Maternity, entire document • III.CCC.1_CCHA Program Description - Member Support Services, entire document • III.CCC.1_CCHA Program Description - Outreach Care Specialist and Peer Support Specialist, entire document • III.CCC.1_CCHA Program Description - Pediatrics - Foster Care, entire document • III.CCC.1_CCHA Program Description - Specialized Transitions of Care, entire document • III.CCC.1_CCHA Prog Description - Transitions of Care, entire document *CCHA delegates care coordination to ACN providers for members that are attributed to ACN practices. Tasks associated with this delegation, along with a list of ACN partners and associated contracts are outlined in the desk review form.* • III.CCC.1_CCHA PCMP Contract Template, pgs. 22-23 *The following document provides an overview of the procedure to monitor call interactions with the Member Support Services team to ensure staff provide members*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with comprehensive information on benefits and respond to member questions accurately and in a timely manner. • III.CCC.1_CCHA_Member Support Services Call Monitoring Procedure, entire document *The following document provides an overview of the Single Entry Point (SEP) and Community Centered Board (CCB) Incentive Program, which incents participating entities to help reduce duplication across the health continuum and control costs.* • III.CCC.1_2021 CCHA SEP CCB Incentive Program Proposal, entire document	
Findings: CCHA documents clearly detailed internal CCHA care coordination procedures, program descriptions that contained outreach and monitoring expectations, and methods of communicating with entities involved in member care. However, a significant percentage of member care coordination occurred through ACN delegates. Delegated care coordination activities ranged from three tiers of care: 1) basic medical home models, 2) condition management, and 3) fully delegated to ACN. Although the delegate agreements contained a general statement about referral and collaboration expectations, the agreements did not detail expected mechanisms for the PCMP to inform CCHA about high-risk members or members for whom additional support is needed due to the PCMP not offering specific condition management programs. Staff member interviews indicated the PCMP may communicate with CCHA through email or may meet monthly or quarterly with CCHA care coordination staff to discuss high-risk members. However, the documentation did not clearly describe PCMP expectations regarding referral procedures or timeliness.		
Required Actions: CCHA must strengthen applicable documents and create a more detailed procedure that outlines referral procedures and timeliness expectations and how CCHA ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP tier or condition management capabilities.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact their designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 7: Exhibit B6—None	*CCHA has implemented the following policies which outline requirements for ensuring each member has an ongoing source of care and that the member is informed of how to contact their designated person or entity.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 2 • III.CCC.2_CCHA_Member Support Services Policy, pgs. 2, 3 *The following program description examples demonstrate that behavioral health members have an ongoing source of care appropriate to their needs and designates a lead care coordinator responsible for coordinating care.* • III.CCC.1_CCHA Program Description - Behavioral Health Transitions of Care, pg. 5 • III.CCC.1_CCHA Program Description - Specialized Transitions of Care, pg. 5 *The following document serves as a member guide, informing members of CCHA's care coordination services, and how to contact CCHA for assistance. It is available in English and Spanish.* • III.CCC.2_CCHA_Map_to_Medicaid_ENG, entire document • III.CCC.2_CCHA_Map_to_Medicaid_SP, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document serves as a quick reference guide for members about accessing behavioral health services, and is available in English and Spanish. • III.CCC.2_BH Reference Guide_ENG, entire document • III.CCC.2_BH Reference Guide_SP, entire document *Customizable enrollment cards are available to members in both English and Spanish. It can be completed by the member or their care coordinator, and includes space to document their provider's name and number, and their Health First Colorado ID number.* • III.CCC.2_CCHA Member Enrollment Card R6, entire document • III.CCC.2_CCHA Member Enrollment Card R6_SP, entire document • III.CCC.2_CCHA Member Enrollment Card R7, entire document • III.CCC.2_CCHA Member Enrollment Card R7_SP, entire document *This insert provides information for members regarding CCHA's care coordination services.* • III.CCC.2_CCHA_CC_Insert_ENG_and_SP, entire document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document provides an overview of the process CCHA uses to ensure that each behavioral health member has an ongoing source of care appropriate to their needs. • III.CCC.2_Behavioral Health Utilization Management Review Workflow, entire document	
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 7: Exhibit B6—6.8.1	*The following document outlines CCHA's policy regarding reviewing attribution assignments.* • III.CCC.3_Member Attribution Review Policy, entire document *CCHA's program description for the Member Support Services team outlines the procedure followed to support these attribution and assignment comparisons and member outreach.* • III.CCC.1_CCHA Program Description - Member Support Services, pg. 5 *CCHA has implemented a tiered per-member per-month payment methodology for PCMPs, which incentivizes providers to outreach members who do not have a prior claims history with the provider.* • III.CCC.3_CCHA_PCMP Payment Methodology, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extended assistance and include appropriate interventions. Contract Amendment 7: Exhibit B6—11.3.3	*CCHA's Care Coordination Operating Policy, in addition to the care coordination procedures outlined in the program descriptions below, ensures care coordination includes a range of deliberate and extended interventions to coordinate with other aspects of the health system. Emphasis is placed on members identified to be high-risk, high-need, or high-cost to ensure active management of these members.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 1-2 *Further, CCHA's program descriptions, PCMP contract template, SEP and CCB memoranda of understanding (MOUs) and workflows, practice support materials, and sample contracts outlined below provide evidence of CCHA's efforts to coordinate with other aspects of the health system.* • Program Descriptions: – III.CCC.1_CCHA Program Description - Adult Integrated Systems, entire document – III.CCC.1_CCHA Program Description - Behavioral Health Transitions of Care, entire document – III.CCC.1_CCHA Program Description - Chronic Disease Management, entire document – III.CCC.1_CCHA Program Description - Complex Care Coordination, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– III.CCC.1_CCHA Program Description - Justice Involved, entire document – III.CCC.1_CCHA Program Description - Maternity, entire document – III.CCC.1_CCHA Program Description - Member Support Services, entire document – III.CCC.1_CCHA Program Description - Outreach Care Specialist and Peer Support Specialist, entire document – III.CCC.1_CCHA Program Description - Pediatrics - Foster Care, entire document – III.CCC.1_CCHA Program Description - Specialized Transitions of Care, entire document – III.CCC.1_CCHA Prog Description - Transitions of Care, entire document • MOUs and Workflows: – III.CCC.4_Adult Care Management, Inc_CCHA_Health Neighborhood MOU (R6), pgs. 2-3) – III.CCC.4_ACMI Workflow (R6), entire document – III.CCC.4_Developmental Disabilities Resource Center_CCHA_Health Neighborhood MOU (R6), pgs. 2-3 – III.CCC.4_DDRC Workflow (R6), entire document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– III.CCC.4_The Resource Exchange CCHA Health Neighborhood MOU (R7), pgs. 2-3 – III.CCC.4_TRE CCHA Workflow (R7), entire document • Practice Support: – III.CCC.4_CCHA Practice Support Plan_R6, pgs. 2, 3, 5-6 – III.CCC.4_CCHA Practice Support Plan_R7, pgs. 2, 3, 5-6 – II.CCC.4_CCHA PMCP Incentive_2021, entire document – III.CCC.4_CCHA ACN Incentive_2021, entire document • Sample Contract: – III.CCC.1_CCHA PCMP Contract Template, pg. 24 *The following documents demonstrate how the SEP & CCB Incentive Program helps improve member health outcomes and ensure members are connected to the appropriate services at the right time.* • III.CCC.4_2022 CCHA SEP CCB Incentive Program, entire document • III.CCC.4_OLTC_CCHA_SEP CCB Performance Pool Letter_1.5.2022 (R6), entire document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document demonstrates how CCHA shares member data with the community mental health centers (CMHCs) to help drive member outcomes related to treatment, outreach, and engagement in services. • III.CCC.4._CMHC Data Sharing Workflow, entire document *The following Community Incentive Program projects serve to help facilitate the appropriate delivery of health and social services to support member health and wellbeing.* • III.CCC.4_Benefits in Action Region 6_CCHA_CIP Agreement_1.1.22, entire document • III.CCC.4_Benefits in Action Region 7_CCHA_CIP Agreement_1.1.22, entire document • III.CCC.4_Colorado Nonprofit Development Center dba Benefits in Action_CCHA_CIP Agreement_1.1.2021, entire document • III.CCC.4_Colorado Springs Fire Dept Community and Public Health_CCHA_CIP Agreement_2.2.21 (R7), entire document • III.CCC.4_Evergreen Christian Outreach_CCHA_CIP Agreement_1.1.22 (R6), entire document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following letter of intent documents the partnership formed with Colorado Health Institute's Community Ambassador Program, which was focused on helping improve COVID-19 vaccination rates among members. • III.CCC.4_Colorado_Health_Institute_CCHA_LOI_ 7.1.2021, entire document	
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)*	*CCHA's policy on care coordination, in addition to the procedures outlined in the program descriptions below, ensures that care is coordinated between settings of care, with services members receive from any other managed care plan, with fee-for-service Medicaid, and with services from community providers.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 2 *Further, CCHA's program descriptions and county collaborative management program memorandums of understanding (MOUs) outlined below provide evidence of CCHA's collaboration with social service provider and efforts to coordinate services furnished to members.* • Program Descriptions: – III.CCC.1_CCHA Program Description - Adult Integrated Systems, entire document – III.CCC.1_CCHA Program Description - Behavioral Health Transitions of Care, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 7: Exhibit B6—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 14.3	– III.CCC.1_CCHA Program Description - Chronic Disease Management, entire document – III.CCC.1_CCHA Program Description - Complex Care Coordination, entire document – III.CCC.1_CCHA Program Description - Justice Involved, entire document – III.CCC.1_CCHA Program Description - Maternity, entire document – III.CCC.1_CCHA Program Description - Member Support Services, entire document – III.CCC.1_CCHA Program Description - Outreach Care Specialist and Peer Support Specialist, entire document – III.CCC.1_CCHA Program Description - Pediatrics - Foster Care, entire document – III.CCC.1_CCHA Program Description - Specialized Transitions of Care, entire document – III.CCC.1_CCHA Prog Description - Transitions of Care, entire document • MOUs – III.CCC.5_Boulder County CMP MOU_FY 21-22 (R6), entire document – III.CCC.5_ Broomfield CMP MOU_FY 21-22 (R6), entire document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– III.CCC.5_El Paso County CMP MOU_FY 21-22 (R7), entire document – III.CCC.5_Park County CMP MOU_FY 21-22 (R7), entire document *CCHA distributes the following referral forms to providers and community partners as a vehicle to refer members to CCHA for care coordination.* • III.CCC.5_CC Referral Form R6, entire document • III.CCC.5_CC Referral Form R7, entire document	
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 7: Exhibit B6—7.5.2–3	*This workflow documents CCHA's process for daily intake of health needs survey data from HCPF and the process for outreaching the member.* • III.CCC.6_Enrollment Broker HNS Workflow, entire document *CCHA's Member Support Services Policy includes information on the health needs survey outreach campaign.* • III.CCC.2_CCHA_Member Support Services Policy, pg. 3 *CCHA uses the following health need assessments to help identify members who may need additional support.* • III.CCC.6_Adult HNA Assessment, entire document • III.CCC.6_Peds HNA Assessment, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems *42 CFR 438.208(c)(2-3)* Contract Amendment 7: Exhibit B6—14.7.1	*CCHA's Care Coordination and Member Support Services policies outline expectations for intake and assessment of members.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 2 • III.CCC.2_CCHA_Member Support Services Policy, pg. 2 *CCHA's program descriptions include procedures to provide an intake and assessment to determine member needs and gather information to build a care plan and includes mechanisms to collaborate with other members of the care team when members are involved in multiple systems and facilitate transitions in care. An example is provided below.* • III.CCC.1_CCHA Program Description - Pediatrics - Foster Care, pgs. 4-5 *The following sample letter is used by care coordination to engage with other providers serving a member.* • III.CCC.7_RAE PCP Collaboration Letter, entire document *This requirement is evidenced by CCHA's care coordination assessments, samples of which are provided below.* • III.CCC.6_Adult HNA Assessment, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• III.CCC.6_Peds HNA Assessment, entire document • III.CCC.7_CCHA Community Resources Referred, entire document • III.CCC.7_Diabetes Assessment, entire document • III.CCC.7_Maternity Assessment, entire document • III.CCC.7_STOC Episode Tracking, entire document *CCHA's Behavioral Health Provider Manual defines requirements for each member to receive an intake assessment, for a care plan to be built based on the intake assessment findings, and for continuity of care.* • III.CCC.7_CCHA Behavioral Health Provider Manual, pgs. 16-18, 72-73 *The following MOUs are examples of partnerships with community entities to coordinate and provide continuity of care for members who are involved in the justice system as they experience service transitions.* • III.CCC.7_4th_Judicial_Probation_HN_MOU, entire document • III.CCC.7_CCHA_Network_Form_4th_Judicial _Probation, entire document • III.CCC.7_CCHA_Network_Form_DRAFT _Intervention_Inc.-ICCS, entire document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• III.CCC.7_GEO_Reentry_Inc._CCHA_Community _Network_MOU_AMD_1_7.1.21, entire document • III.CCC.7_Intervention_Inc._CCHA_Community _Network_MOU_11.30.20, entire document	
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 7: Exhibit B6—None	*CCHA's Care Coordination Operating Policy includes a statement that CCHA shares information about a member's needs with other entities serving the member to prevent duplication of services.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 2 *The following sample letter is used by care coordination to engage with other providers serving a member.* • III.CCC.7_RAE PCP Collaboration Letter, entire document *The following documents are examples of different ways in which CCHA shares member data with other entities to prevent duplication of services.* • Program Descriptions – III.CCC.1_CCHA Program Description - Behavioral Health Transitions of Care, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– III.CCC.1_CCHA Program Description - Specialized Transitions of Care, entire document • Case Reviews – III.CCC.8_CCHA Jeffco DHS Monthly Meeting Notes (R6), entire document – III.CCC.8_Clinica Complex Case Review (R6), entire document – III.CCC.8_CCHA Care Conference Example 10.5.2021 (R7), entire document – III.CCC.8_Peak Vista Monthly Case Review 9.14.21 (R7), entire document – III.CCC.8_Rocky Mountain Human Services (RMHS) Complex Case Review (R7), entire document – III.CCC.8_Rocky Mountain Human Services (RMHS) Monthly Meeting Notes 2.22.22 (R6), entire document • SEP and CCB Collaboration – III.CCC.4_Adult Care Management, Inc_CCHA_Health Neighborhood MOU (R6) – III.CCC.4_Developmental Disabilities Resource Center_CCHA_Health Neighborhood MOU (R6) – III.CCC.4_The Resource Exchange CCHA Health Neighborhood MOU (R7)	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– III.CCC.1_2021 CCHA SEP CCB Incentive Program Proposal • CMHC Collaboration – III.CCC.8_Region 6 Complex Case Review with MHP and JCMH, entire document – III.CCC.8_Example of MHP Treatment Team Review (R6), entire document – III.CCC.8_Region 7 CMHC Desk Top Process, entire document – III.CCC.4_CMHC Data Sharing Workflow	
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* Contract Amendment 7: Exhibit B6—11.3.7.10.6, 15.1.1.5	*The following behavioral health provider agreement template outlines CCHA's expectations for maintaining and sharing member health records and protecting member privacy.* • III.CCC.9_CCHA BH Provider Agreement Template, pgs. 6-7 *CCHA's Behavioral Health Provider Manual outlines requirements for maintaining member health records and protecting member privacy.* • III.CCC.7_CCHA Behavioral Health Provider Manual, pgs. 80, 90-92 *The following PCMP provider agreement template outlines CCHA's expectations for maintaining and sharing member health records and protecting member privacy.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• III.CCC.1_CCHA PCMP Contract Template, pg. 24 *CCHA's Physical Health Provider Manual outlines requirements for maintaining member health records and protecting member privacy.* • III.CCC.9_CCHA Physical Health Provider Manual, pg. 28 *The following policy includes a statement that CCHA ensures that each member's privacy is protected in the process of coordinating care, in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent they are applicable.* • III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 3 *The following policy acknowledges members' right to have their medical record and information protected in accordance with HIPAA and all other applicable privacy laws.* • III.CCC.9_CCHA_Member Rights and Responsibilities Policy, pg. 4 *The following policy includes the provision that CCHA will reasonably ensure that personnel only have access to and share the minimum amount of information necessary to*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	conduct business where PHI is used or disclosed, and will protect member privacy in accordance with HIPAA. • III.CCC.9_CCHA_Privacy Policy, pg. 4 *CCHA uses the following release of information form to document member consent and specifications around sharing the member's protected health information.* • III.CCC.9_Member ROI Form, entire document *CCHA uses the following form to determine whether an agency may be a Covered Entity, with whom CCHA may share PHI without a specific release in accordance with HIPAA.* • III.CCC.9_Covered Entity Form, entire document	
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of	*The following screenshot from CCHA's electronic care coordination tool demonstrate the ability to collect member name, Medicaid ID, age, gender, name of entity/person providing care coordination, designated lead care coordinator, other entities servicing the member, stratification level, assessments, care plan goals, tasks, notes, and correspondence.* • III.CCC.10_Essette Screenshot, entire document *CCHA's Care Coordination Operating Policy includes the provision that care coordination activities and member information are documented in Essette.* • III.CCC.7_CCHA_Care Coordination Operating Policy, pgs. 2, 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 7: Exhibit B6—15.2.1.1, 15.2.1.3-4	*The following health needs assessments demonstrate collection of information that can be used to create a care plan and goals for the member. These assessments also collect the member's self-reported race and identifies the lead care coordinator.* • III.CCC.6_Adult HNA Assessment, entire document • III.CCC.6_Peds HNA Assessment, entire document	

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	9
				Total Score ÷ Total Applicable		=	90%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 7: Exhibit B6—7.3.7.1–2	*The following documents are all related to the member rights and protections specified in this standard.* • IV.MRP.1_CCHA_Member Rights and Responsibilities Policy, entire document • IV.MRP.1_CCHA_Member Grievances Policy, entire document • IV.MRP.1_ CCHA_Privacy Policy, entire document • IV.MRP.1_ CCHA_Member and Provider Materials and Website Policy, entire document • IV.MRP.1_ CCHA_ADA Compliance for Network Providers Policy, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 7: Exhibit B6—17.10.7.2	*The following policy informs employees of applicable member rights and their duty to observe and protect said rights. The attestation demonstrates that all member-facing staff completed this annual training.* • IV.MRP.1_CCHA_Member Rights and Responsibilities Policy, pg. 2 • IV.MRP.2_CCHA Staff Training Attestation - Member Rights and Advance Directives, entire document *The CCHA website provides members with information regarding member rights and their ability to exercise said rights without retaliation. Additionally, CCHA provides a link to the Health First Colorado Member Handbook to learn more.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/frequently-asked-questions *The Physical and Behavioral Health Provider Manuals inform network providers of member rights and responsibilities.* • IV.MRP.2_CCHA Behavioral Health Provider Manual, pgs. 102-103 • IV.MRP.2_CCHA Physical Health Provider Manual, pg. 12 *To further inform the provider network, CCHA published the member rights and responsibilities in the Provider Newsletter.* • IV.MRP.2_CCHA Newsletter October 2021, pg. 3	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for their dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	*The following policy contains the member rights found in this requirement. The attestation demonstrates that all member-facing staff completed this annual training.* • IV.MRP.1_CCHA_Member Rights and Responsibilities Policy, pgs. 2-4 • IV.MRP.2_CCHA Staff Training Attestation - Member Rights and Advance Directives, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 7: Exhibit B6—7.3.7.2.1–6	*The following policy provides information on an individual's right to access PHI as contained in a designated record set, as well as information regarding a member's right to amend their PHI.* • IV.MRP.1_CCHA_Privacy Policy, pgs. 7-8, 14 *The following document outlines the policy for an individual to request access to or a copy of their PHI in a designated record set maintained by CCHA, along with the procedure to approve or deny a request.* • IV.MRP.3_CCHA_Individual Access to Designated Record Set Policy, entire document *The CCHA website provides members with information regarding member rights and their ability to exercise said rights without retaliation.* • https://www.cchacares.com/for-members/frequently-asked-questions *The following documents are examples of documents available to members that meet the requirements set forth in 42 CFR 438.10.* • IV.MRP.3_CCHA Member Enrollment Card R6, entire document	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• IV.MRP.3_CCHA Member Enrollment Card R6 _SP, entire document • IV.MRP.3_CCHA Member Enrollment Card R7, entire document • IV.MRP.3_CCHA Member Enrollment Card R7 _SP, entire document *The following policy and corresponding template demonstrate how CCHA ensures member rights are protected when establishing a communication plan, when warranted.* • IV.MRP.3_CCHA_Member Communication Plan Policy, entire document • IV.MRP.3_CCHA_Member Communication Plan_Template, entire document	
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 7: Exhibit B6—7.3.7.2.7	*The following policy includes the right for members to use their rights without fear of being treated poorly. While CCHA cannot control the actions of HCPF, CCHA staff will always work with HCPF and the member to ensure the member's rights are being preserved and the member is not adversely impacted in any way due to exercising said rights. The attestation demonstrates that all member-facing staff completed this annual training.* • IV.MRP.1_CCHA_Member Rights and Responsibilities Policy, pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• IV.MRP.2_CCHA Staff Training Attestation - Member Rights and Advance Directives, entire document *The CCHA website provides members with information regarding member rights and their ability to exercise said rights without retaliation. Additionally, CCHA provides a link to the Health First Colorado Member Handbook to learn more.* • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/frequently-asked-questions *The Provider Manuals provide information regarding member rights to CCHA network providers.* • IV.MRP.2_CCHA Behavioral Health Provider Manual, pg. 103 • IV.MRP.2_CCHA Physical Health Provider Manual, pg. 12 *The following document informs members that they may change their primary care provider at any time and directs them how to do so.* • IV.MRP.4_Change PCP Card, entire document	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 7: Exhibit B—11.3.7.10.6, 15.1.1.5	*The following policy demonstrates compliance with this requirement by outlining CCHA's policies regarding member privacy and member PHI, including the confidentiality of patient information, the use and disclosure of member PHI where authorization is not required, and the use and disclosure of member PHI where authorization is required.* • IV.MRP.1_CCHA_Privacy Policy, pg. 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection.	*The following policy demonstrates CCHA's responsibilities towards its members, providers, and staff regarding advance directives, and contains all the requirements required by the contract and federal regulations.* • IV.MRP.6_CCHA_Advance Directives Policy, entire document *The following document demonstrates that CCHA's Care Coordination staff received training around advance directives.* • IV.MRP.2_CCHA Staff Training Attestation - Member Rights and Advance Directives, entire document *The following program description is an example that demonstrates that CCHA's care coordinators provide education to members and their families about*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate of staff concerning its policies and procedures on advance directives.	*advance directive options and tools, when appropriate.* • IV.MRP.6_CCHA Program Description - Complex Care Management, pg. 6 *Information regarding advance directives is provided to behavioral health providers via the provider manual.* • IV.MRP.2_CCHA Behavioral Health Provider Manual, pg. 92 *Information regarding advance directives is provided to physical health providers via the provider manual.* • IV.MRP.2_CCHA Physical Health Provider Manual, pgs. 14, 23, 33 *CCHA's December 2021 Provider Newsletter included an article to educate network providers and community partners on advance care planning and available resources.* • IV.MRP.6_CCHA Newsletter December 2021, pg. 7 *CCHA's website provides information to members regarding advance directives and provides a link to the Health First Colorado Member Handbook for additional information.* • https://www.cchacares.com/advancedirectives	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 7: Exhibit B6—7.3.11.2, 7.3.11.3.3	• https://www.cchacares.com/for-members/frequently-asked-questions • CCHA Health Topics Library - Advance Directives • https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook • IV.MRP.6_Health First Colorado Member Handbook, pg. 12 • IV.MRP.6_Health First Colorado Member Handbook_SP, pgs. 11-12 • IV.MRP.6_CCHA Website_ Advance Care Planning, entire document *The following documents serve as resource guides for members and provides information on how CCHA can support advance care planning.* • IV.MRP.6_Advance Care Planning Resources, entire document • IV.MRP.6_ Advance Care Planning Resources_SP, entire document • IV.MRP.6_Five Wishes Flyer, entire document *CCHA shared the following email with the Program Improvement Advisory Committee (PIAC) participants, comprised of community partners, providers, and members, which included resources and information about advance care planning.*	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• IV.MRP.6_CCHA_PIAC Updates Email March 2022, pg. 2	

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit B6—7.2.5, 7.3.6.1	*The following document outlines the language and accessibility requirements as they relate to member materials, including CCHA's requirement for member testing and its definition of large-scale communications.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 7: Exhibit B6—7.38.1	*The Health First Colorado website contains valuable information for members regarding their benefits under Medicaid and any cost sharing requirements.* • https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook *The CCHA website contains information about the benefits and services that CCHA provides.* • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/get-help	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA's Frequently Asked Questions webpage includes answers to common questions about benefits, services, and requirements of the plan. • https://www.cchacares.com/for-members/frequently-asked-questions *The following documents outline the services CCHA provides to members and how to access services.* • V.MI.2_CCHA_Map_to_Medicaid_ENG, entire document • V.MI.2_CCHA_Map_to_Medicaid_SP, entire document • V.MI.2_CCHA_Health First Colorado FAQ, entire document *The following documents describe how the Member Support Services team assists members to understand their benefits and access services.* • V.MI.2_CCHA Program Description - Member Support Services, entire document • V.MI.2_CCHA Member Support Services Policy, entire document *CCHA produced an American Sign Language (ASL) Interpreted Medicaid Benefits and Services Webinar to educate members who are d/Deaf or hard-of-hearing about Medicaid benefits and services and how CCHA can help.* • https://www.cchacares.com/ASLMedicaid	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit B6—3.6, 7.3.4	*Although this requirement is not applicable, CCHA has included this requirement in the following policy to ensure compliance with federal and contractual requirements.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 2 *The following document is an example of a member communication notice that is modeled after the HCPF template.* • V.MI.3_CO Notice of Adverse Benefit Determination Letter ENG, entire document • V.MI.3_CO Notice of Adverse Benefit Determination Letter SP, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Requirement is applicable and evaluated based on CCHA's informational materials, policies, and procedures.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3	*The following document contains all information from this requirement, including the definition of prevalent non-English languages that are present in CCHA's service regions.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 2 *The following document provides a visual overview of the member testing process.* • V.MI.4_CCHA Member Testing Process, entire document *All pages on CCHA's website include instructions on how to receive information in alternative formats. CCHA also provides links to the Health First Colorado Member Handbook via the Member Benefits and Services and FAQ pages.* • https://www.cchacares.com *The CCHA Provider Directory allows members to copy, print or export into CSV, Excel, or PDF a copy of the directory, as well as information on how to request a paper version or alternative format from Member Support Services.* • https://www.cchacares.com/for-members/find-a-provider	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA developed the following document to train staff and some community partners on how to use the online CCHA Provider Directory. • V.MI.4_CCHA_Provider Search Guide, entire document *The following notice of adverse benefit determination letter is the CCHA version of the state developed template that is sent to a member when CCHA makes an adverse benefit determination, which complies with all language requirements.* • V.MI.3_CO Notice of Adverse Benefit Determination Letter ENG, entire document • V.MI.3_CO Notice of Adverse Benefit Determination Letter SP, entire document *The following documents are examples of letters sent to members which comply with all information requirements.* • V.MI.4_Member Complaint Acknowledgement Letter ENG, entire document • V.MI.4_Member Complaint Acknowledgement Letter SP, entire document • V.MI.4_Member Complaint Resolution Letter ENG, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.4_Member Complaint Resolution Letter SP, entire document • V.MI.4_CO UM Denial Letter ENG, entire document • V.MI.4_CO UM Denial Letter SP, entire document • V.MI.4_CO UM Retro Adverse Action Letter ENG, entire document • V.MI.4_CO UM Retro Adverse Action SP, entire document • V.MI.4_CO AG Appeal Ack Ltr-Verbal ENG, entire document • V.MI.4_CO AG Appeal Ack Ltr-Verbal SP, entire document • V.MI.4_CO AG Appeal Ack Letter-Written ENG, entire document • V.MI.4_CO AG Appeal Ack Letter-Written SP, entire document • V.MI.4_CO AG Appeal Past Timely Filing Ltr ENG, entire document • V.MI.4_CO AG Appeal Past Timely Filing Ltr SP, entire document • V.MI.4_CO AG Appeal Admin Uphold Ltr ENG, entire document • V.MI.4_CO AG Appeal Admin Uphold Ltr SP, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.4_CO AG Appeal Time Frame Ext Notif Ltr ENG, entire document • V.MI.4_CO AG Appeal Time Frame Ext Notif Ltr SP, entire document • V.MI.4_CO AG Appeal Dismiss Letter ENG, entire document • V.MI.4_CO AG Appeal Dismiss Letter SP, entire document • V.MI.4_CO AG Appeal Internal Rights Exhausted ENG, entire document • V.MI.4_CO AG Appeal Internal Rights Exhausted SP, entire document • V.MI.4_CO AG Appeal Medical Necessity Uphold Ltr ENG, entire document • V.MI.4_CO AG Appeal Medical Necessity Uphold Ltr SP, entire document • V.MI.4_CO AG Appeal Overturn Ltr ENG, entire document • V.MI.4_CO AG Appeal Overturn Ltr SP, entire document • V.MI.4_CO AG Appeal Withdrawal Ltr ENG, entire document • V.MI.4_CO AG Appeal Withdrawal Ltr SP, entire document	
Findings: The *Member and Provider Materials and Website* policy described procedures for ensuring that member informational materials contain taglines in large print (conspicuously visible font size) and prevalent non-English languages describing how to request auxiliary aids and		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
services, including written translation or oral interpretation, the toll-free and TTY/TDD customer service numbers, and availability of materials in alternative formats. However, some critical member materials did not include all required components of a tagline. • The *Member Complaint Resolution Letter* had a tagline, but the tagline did not describe how to request auxiliary aids and services, including written translation or oral interpretation and that information is available in alternative formats upon member request at no cost. Additionally, the translated Spanish tagline was not in a conspicuously visible font size. • The *Notice of Adverse Benefit Determination* letter had a tagline, but the Spanish tagline did not include that, upon request, information is available at no cost to the member, and the English tagline did not include that information is available in alternative formats. • The *Map to Medicaid*, *Maternity Brochure*, *Foster Care Children & Caregiver Resources Member Guide Insert*, *Care Coordination Benefits Member Insert*, and *Well Child Insert* did not have a tagline in English and Spanish. • The EPSDT flyer had a tagline but did not include "no cost" to the member. The English copy did not have the tagline written in Spanish. • The taglines varied greatly across the documents submitted for review. Materials that are critical to obtaining services must include taglines, and the materials on this list contained critical information about CCHA members accessing care and understanding core programs that CCHA offers.		
Required Actions: CCHA must revise critical member materials to include all required components of a tagline. HSAG recommends CCHA standardize the tagline across all critical informational materials.		
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements.	*The following policy includes the criteria outlined in this requirement for member information that is made available electronically.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 4 *All pages on the CCHA website include instructions on how to receive information in alternative formats, and that information will be provided in paper form free of charge within five business days.* • https://www.cchacares.com	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	• V.MI.5_CCHA _Get Help screenshot, entire document *CCHA's Member Benefits and Services webpage provides links to the Health First Colorado website via the "Learn more about Health First Colorado benefits" and "Get your Health First Colorado Member Handbook" buttons.* • https://www.cchacares.com/for-members/member-benefits-services	
Findings: Staff members discussed the turnaround timelines for ad hoc requests for printed materials, provided screenshots of the Essette system where ad hoc requests could be documented, and provided email evidence that demonstrated an example of receiving and responding to such requests. For this example, staff mailed the requested materials within two days. However, the screenshot in Essette submitted as evidence stated that it "will take five to seven business days for the member to receive" the informational materials, further indicating a timely ad hoc printing and mailing process is not clear to staff members or documented in procedures. CCHA did not provide any supporting document regarding monitoring that ad hoc requests are printed and mailed to members within five business days.		
Required Actions: CCHA must develop a mechanism to ensure that, upon request, members are provided with printed materials within five business days and at no cost.		
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format.	*CCHA's Frequently Asked Questions webpage provides a link for members to the Health First Colorado Pharmacy Benefits page under the "What prescription drugs does Health First Colorado Cover?" section for the most up to date information. CCHA does not produce its own formulary as it does not manage the prescription drug benefit.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(i) Contract Amendment 7: Exhibit B6—None	• https://www.cchacares.com/for-members/frequently-asked-questions	
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 7: Exhibit B6—7.2.6.2–4	*The following policy outlines CCHA's requirements as related to oral interpretation services and availability of written translation.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pgs. 2-3 *Information regarding interpretation services and auxiliary aids is provided to behavioral health providers via the Provider Manual.* • V.MI.7_CCHA Behavioral Health Provider Manual, pgs. 71, 78 *Information regarding interpretation services and auxiliary aids is provided to physical health providers via the Provider Manual.* • V.MI.7_CCHA Physical Health Provider Manual, pgs. 3, 25-26. *The following CCHA webpages inform members they have access to oral interpretation services and how to request such services.* • https://www.cchacares.com/for-members/frequently-asked-questions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• https://www.cchacares.com/non-discrimination-notice *Further, a standard footer at the bottom of each page on the CCHA website lists different languages that link to CCHA's language page. The message states, "ATTENTION: If you speak [language here], free language assistance services are available to you."* • https://www.cchacares.com/languages *The following policy outlines the process by which CCHA facilitates language assistance services.* • V.MI.7_Language Assistance Services Policy, entire document *The following documents outline the process of requesting interpretation services.* • V.MI.7_CCHA Interpretation for Deaf and Hard of Hearing Desktop Guide, entire document • V.MI.7_Spoken and Written Language Interpretation Desktop Guide, entire document • V.MI.7_Use of Auxiliary Aids Desktop Guide, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 7: Exhibit B6—7.2.6.1, 7.2.6.5	*The following policy addresses CCHA's policy to ensure language assistance is provided to members.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 3 *The following policy outlines that CCHA shall facilitate the provision of language assistance services.* • V.MI.7_Language Assistance Services Policy, pg. 2 *The following policy outlines expectations for staff and provider competency regarding culturally and linguistically appropriate services (CLAS).* • V.MI.8_CCHA CLAS Policy, entire document *CCHA communicates these requirements to behavioral health providers via the Provider Manual.* • V.MI.7_CCHA Behavioral Health Provider Manual, pgs. 71, 78 *CCHA communicates these requirements to physical health providers via the Provider Manual.* • V.MI.7_CCHA Physical Health Provider Manual, pgs. 25-26	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* Contract Amendment 7: Exhibit B6—7.3.8.1	*Not applicable. CCHA does not produce a member handbook; however, links to the Health First Colorado Member Handbook are available on the following CCHA webpages:* • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/get-help *Instructions: Unless the RAE has its own handbook or supplement, score this Not Applicable.*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 7: Exhibit B6—7.3.8.2	*Not applicable. CCHA does not produce a member handbook; however, links to the Health First Colorado Member Handbook are available on the following CCHA webpages:* • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/get-help *Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable.*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g).	*Not applicable. CCHA does not produce a member handbook; however, links to the Health First Colorado Member Handbook are available on the following CCHA webpages:* • https://www.cchacares.com/for-members/member-benefits-services	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 7: Exhibit B6—7.3.8.1	• https://www.cchacares.com/for-members/get-help *Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable. If the RAE produces its own handbook or supplemental handbook—(a) review for accuracy of any applicable elements and (b) must reference the Department's handbook.*	
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit B6—7.3.10.1	*The following policy outlines CCHA's policy regarding the notification of members when a provider or practice leaves the network.* • V.MI.12_CCHA_Notice of a Provider Termination or Practice Closure Policy, pg. 2 *The following document outlines the process for notifying members when a PCMP is terminated from the CCHA network.* • V.MI.12_CCHA_PCMP Network Disaffiliation Procedure, entire document *The following letter is sent to members when their PCMP or physical health practice is closing or leaving the CCHA network, and is available in English and Spanish.* • V.MI.12_CCHA_Practice Closure Template (announcing closure)_ENG, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.12_CCHA_Practice Closure Template (announcing closure)_SP, entire document *The following letter is sent to members when their PCMP or physical health practice has closed or has left the CCHA network, and is available in English and Spanish.* • V.MI.12_CCHA_Practice Closure Member Letter_ENG, entire document • V.MI.12_CCHA_Practice Closure Member Letter_SP, entire document *The following document outlines the process for notifying members when a behavioral health provider is terminated from the CCHA network.* • V.MI.12_CCHA_Behavioral Health Provider Termination Letter Procedure, entire document *The following letter is sent to members when their behavioral health provider leaves the CCHA network, and is available in English and Spanish.* • V.MI.12_CO OP Behavioral Health Termination Letter-ENG, entire document • V.MI.12_CO OP Behavioral Health Termination Letter-SP, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • The RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory. • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 7: Exhibit B6—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	*The following policy outlines CCHA's website requirements.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 4 *CCHA's website contains all of the requisite information as follows.* *RAE's contact information:* • https://www.cchacares.com/about-ccha/contact-us • https://www.cchacares.com/for-members/member-assistance *Member rights and handbooks:* • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/frequently-asked-questions *Grievance and appeal procedures and rights:* • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/appeals-and-grievances	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/member-benefits-services *General functions of the RAE:* • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/connect-with-a-care-coordinator • https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/about-ccha/overview-structure *Trainings for providers:* • https://www.cchacares.com/for-providers/provider-resources-training *Training for members:* • Health Topics Library • https://www.cchacares.com/aslmedicaid	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Provider directory: • https://www.cchacares.com/for-members/find-a-provider *Access to care standards:* • https://www.cchacares.com/for-members/frequently-asked-questions *Health First Colorado Nurse Advice Line:* • https://www.cchacares.com/for-members/contact-information-resources • https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/get-help *Colorado Crisis Services information:* • https://www.cchacares.com/for-members/contact-information-resources • https://www.cchacares.com/for-members/options • https://www.cchacares.com/behavioralhealth *A link to the Department's website for standardized information such as member rights and handbooks:* • https://www.cchacares.com/for-members/member-benefits-services	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/appeals-and-grievances	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.*	*CCHA's Provider Directory is updated daily, and contains the following provider-attested information on contracted network providers:* • *The name and practice name, street address, telephone number, website (if available)* • *Whether the provider is accepting new patients* • *Languages spoken and whether the provider has completed cultural competency training* • *Provider or practice type (search by specialty)* • *Whether the provider's office has accommodations for members with disabilities* • *If a member would like a paper version of the directory or the directory in a different format, they can download and print a copy using the search function. Likewise, they can call CCHA Member Support Services and a paper version will be provided free of charge upon request.* • https://www.cchacares.com/for-members/find-a-provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(h)(1-3) Contract Amendment 7: Exhibit B6—7.3.9.1.6-7	*For all other provider types, CCHA links to the HCPF provider directory, as we are only required to report out on our contracted provider types.*	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit B6—7.3.9.1.8	*The CCHA Provider Directory can be exported into CSV, Excel, and PDF formats, with the option to copy or print.* • https://www.cchacares.com/for-members/find-a-provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The RAE's single toll-free customer service phone number. • The RAE's email address. • The RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit.	*The following document serves as a CCHA member guide for Health First Colorado members and includes information on how to contact CCHA and Health First Colorado benefits and services. It is available in both English and Spanish.* • V.MI.2_CCHA_Map_to_Medicaid_ENG, entire document • V.MI.2_CCHA_Map_to_Medicaid_SP, entire document • https://www.cchacares.com/for-members/get-help *The following insert provides information for members regarding CCHA's care coordination services and is available in English and Spanish.* • V.MI.16_CCHA_CC_Insert_ENG_and_SP, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 7: Exhibit B6—7.3.6.1	• https://www.cchacares.com/for-members/connect-with-a-care-coordinator *The following insert provides information for members regarding Health First Colorado dental benefits and is available in English and Spanish.* • V.MI.16_CCHA_Dental_Benefits_ENG and SP_R6, entire document • V.MI.16_CCHA_Dental_Benefits_ENG and SP_R7, entire document • https://www.cchacares.com/dental *The following document provides members with contact information for CCHA, Health First Colorado Nurse Advice Line, and Colorado Crisis Services. It is available in English and Spanish. Similar information is available on the website via the link below.* • V.MI.16_CCHA_ER_Handout_ENG, entire document • V.MI.16_CCHA_ER_Handout_SP, entire document • https://www.cchacares.com/for-members/options *The following insert is used to inform members that they can request assistance with transportation and is available in English and Spanish. Similar information is available on the website via the link below.*	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.16_CCHA_Transportation_Insert_ENG and SP, entire document • https://www.cchacares.com/for-members/transportation *The following document for members serves as a quick reference guide to behavioral health services and is available in English and Spanish.* • V.MI.16_CCHA_BH Reference Guide_ENG, entire document • V.MI.16 CCHA_BH Reference Guide_SP, entire document • https://www.cchacares.com/for-members/substance-use-disorder-treatment-benefits *CCHA's single toll-free customer service phone number is listed on:* • CCHA website Contact Us page • All member facing print materials, a sample of which includes: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP – V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP – V.MI.16_CCHA_ER_Handout_ENG	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– V.MI.16_CCHA_ER_Handout_SP • All member correspondence *CCHA's email address can be found on:* • CCHA website Contact Us page • Contact Us Form *CCHA's website address can be found on:* • All member facing print materials, a sample of which includes: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP – V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP – V.MI.16_CCHA_ER_Handout_ENG – V.MI.16_CCHA_ER_Handout_SP • All member correspondence *CCHA includes State relay information on:* • CCHA website Contact Us page • All member facing print materials including: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP – V.MI.16_CCHA_ER_Handout_ENG – V.MI.16_CCHA_ER_Handout_SP • All member correspondence *The basic features of CCHA's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP) are available on:* • CCHA website Member Benefits & Services page • CCHA website Connect with a Care Coordinator page • CCHA website Frequently Asked Questions page • Member facing print materials including: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP – V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP *Which populations are subject to mandatory enrollment into the Accountable Care Collaborative is located on:*	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CCHA website Frequently Asked Questions page *The service area covered by CCHA is included on:* • CCHA website About Us • CCHA website Member Benefits & Services page • CCHA website Frequently Asked Questions page • Member facing print materials including: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP – V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP *Information on Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit can be found on:* • CCHA website Member Benefits & Services page, link to HealthFirstColorado.com description • CCHA website Member Frequently Asked Questions page • Member facing print materials including: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP *Any restrictions on the member's freedom of choice among network providers:* • Not applicable. CCHA does not restrict member's choice of provider. • Refer to CCHA's Member Rights and Protections Policy and the CCHA website Frequently Asked Questions page *The requirement for CCHA to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards, is included on:* • CCHA website Member Frequently Asked Questions page *Information on CCHA's responsibilities for coordination of member care can be found on:* • CCHA website About Us • CCHA website Member Benefits & Services page • CCHA website Frequently Asked Questions page	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CCHA website Connect with a Care Coordinator page • Member facing print materials including: – V.MI.2_CCHA_Map_to_Medicaid_ENG – V.MI.2_CCHA_Map_to_Medicaid_SP – V.MI.16_CCHA_BH Reference Guide_ENG – V.MI.16 CCHA_BH Reference Guide_SP *CCHA informs members via the Frequently Asked Questions page that CCHA does not restrict or limit any services because of moral or religious objections, and that if their provider will not provide a covered service due to such objections, they may contact CCHA Member Support Services. Additionally, this page informs stakeholders of member satisfaction results from the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey conducted for 2020/2021.* • CCHA website Frequently Asked Questions page *To the extent possible, quality and performance indicators for CCHA can be found on:* • https://www.cchacares.com/about-ccha/advisory-committees/meeting-minutes	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CCHA shares Key Performance Indicator (KPI) and Behavioral Health Incentive Program data with the regional Program Improvement Advisory Committees (PIAC) quarterly. Meeting minutes are provided via the link above.	
Findings: CCHA used the Department's welcome letter and the *Health First Colorado Member Handbook* to inform newly enrolled members about services. HSAG observed that although the welcome letter points members to the *Health First Colorado Member Handbook,* which includes almost all required information, the welcome letter distributed by the Department during CY 2021 did not contain CCHA's website address and neither did the *Health First Colorado Member Handbook.* Based on additional evidence in the form of email communications between CCHA and the Department, CCHA was under the impression that the welcome letter used throughout FY 2021–2022 contained the website address details for each managed care entity. Based on this information, the requirement is considered met. The Department reported that an updated letter that will include the RAE's website address is estimated to go into production in July 2022; therefore, no required action associated with this finding is needed.		
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.	*The following document outlines CCHA's policy for providing information to members, as included in this requirement. Once a member provides their consent to have information submitted electronically, this is noted in CCHA's care coordination tool, Essette, for future reference.* • V.MI.1_CCHA_Member and Provider Materials and Website Policy, pg. 2 *The following document outlines CCHA's policy regarding communicating with members via email or text message.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 7: Exhibit B6—None	• V.MI.17_CCHA_Patient Consent for E-Mail and SMS Text Messaging Policy, entire document *The following document requests consent from a member to allow CCHA staff to use email and text messaging to communicate protected health information (PHI) related to scheduling appointments, community resources, and/or any other care coordination activities that are requested.* • V.MI.17_CCHA_Member Unsecured Email Consent Form, entire document *The following document outlines CCHA's policy related to emailing protected health information (PHI).* • V.MI.17_CCHA_Emailing PHI by Workforce Members Policy, entire document *The following document outlines CCHA's policy regarding the use of communication plans to establish boundaries, if deemed necessary, when communicating with members.* • V.MI.17_CCHA_Member Communication Plan Policy, entire document *The following letter template is used to inform members when a communication plan is put in place*	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and defines the specific ways in which CCHA will communicate with the member to ensure effective care coordination. • V.MI.17_CCHA_Member Communication Plan Template, entire document	
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 7: Exhibit B6—None	*CCHA includes information about its physician incentive plans on the Frequently Asked Questions page of its website.* • https://www.cchacares.com/for-members/frequently-asked-questions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	3	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	87%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Academy of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation. Contract Amendment 7: Exhibit B6—7.3.12.1, 7.6.2	*The following document outlines CCHA's policy and procedure related to EPSDT, which includes providing information to members and their families regarding EPSDT benefits and how to obtain additional information.* • XI.EPSDT.1_CCHA_EPSDT Policy, pgs. 3-4 *The following care coordination program descriptions outline care coordination activities for pediatric, foster care and maternity populations, including activities to inform members and their families regarding EPSDT benefits.* • XI.EPSDT.1_CCHA Program Description - Pediatrics - Foster Care, pg. 6 • XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 6-7 *CCHA's member-facing staff received training on EPSDT benefits and services, and how CCHA can assist members to ensure members are appropriately educated of the availability of such services.* • XI.EPSDT.1_CCHA Staff Training Attestation - EPSDT, entire document *CCHA's website includes information to inform members and their families of EPSDT benefits, where services are available, how to obtain said services, that*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	such services are available without cost to the member, and how to request transportation. • https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/epsdt *The following document demonstrates CCHA's processes to outreach both new enrollees and non-utilizer members to inform them of EPSDT benefits available to them.* • XI.EPSDT.1_CCHA EPSDT Workflow, entire document *The following document is a template used to facilitate case reviews in collaboration with HCPF and other members of the care team, during which member needs are discussed, including services that may be covered under the EPSDT benefit.* • XI.EPSDT.1_CCHA Escalated Case Template Form, entire document *The following EPSDT Annual Plan reports define CCHA's strategic approach to meet the EPSDT outreach responsibilities.* • XI.EPSDT.1_R6_EPSDTPln_FY21-22, pg. 2 • XI.EPSDT.1_R7_EPSDTPln_FY21-22, pg. 2	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Early and Periodic Screening, Diagnostic and Treatment Colorado* policy described that outreach to foster care members occurred through the DHS case workers; however, CCHA reported issues with identifying this member population in two out of the four quarters in the review period, CY 2021. During the interview, CCHA could not confirm 1) the process in which DHS outreached members and did not have a monitoring mechanism to ensure outreach occurred, or 2) a long-term resolution for the foster care data issue. Additionally, CCHA did not outreach members who had not utilized services in the previous 12 months during three of the four quarters. Then in the last quarter of CY 2021, CCHA completed outreach to non-utilizers but noted an issue with data sorting procedures, which lead to inadvertently outreaching members who had utilized services in the previous 12-month period.		
Required Actions: CCHA must develop a process to ensure access to foster data and outreach to newly eligible foster children is completed within 60 days of identification, either by DHS or CCHA. Due to CCHA implementing the outreach procedures for non-utilizers at the end of CY 2021, no required action is necessary. However, HSAG recommends revisiting quality assurance procedures regarding this data set.		
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 7: Exhibit B6—7.6.3.2	*The following policy includes a statement regarding having multiple methods of outreach, using a combination of written and oral materials.* • XI.EPSDT.1_CCHA_EPSDT Policy, pg. 4 *The following documents include a statement regarding care coordination services being delivered through multiple modalities, including in-person, telephonic, video, email, text message, and other forms as appropriate.* • XI.EPSDT.1_CCHA Program Description - Pediatrics - Foster Care, pg. 4 • XI.EPSDT.1_CCHA Program Description - Maternity, pg. 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following policy states the requirement that CCHA will provide all required member information to members in a manner and format that may be easily understood and is readily accessible by members. • XI.EPSDT.2_CCHA Member and Provider Materials and Website Policy, entire document *The following document includes scripted messages used to outreach members via automated phone call and text messaging.* • XI.EPSDT.2_Automated Outreach Scripts, entire document *The following flyer is used to inform members of EPSDT benefits by mail, and is available in English and Spanish.* • XI.EPSDT.2_Flyer Mailing_ENG, entire document • XI.EPSDT.2_Flyer Mailing_SP, entire document *The following insert is used to inform members of EPSDT benefits and is available in English and Spanish.* • XI.EPSDT.2_Well Child Insert_ENG, entire document	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• XI.EPSDT.2_Well Child Insert_SP, entire document *The following document lists the pages on the CCHA website that include EPSDT benefit information for members.* • XI.EPSDT.2_Standard Member URLs, entire document *The following document lists the CCHA webpage that includes EPSDT benefit information for providers.* • XI.EPSDT.2_Standard Provider URLs, entire document • https://www.cchacares.com/for-providers/provider-resources-training *The following CCHA Provider Newsletter includes an article with information about EPSDT benefits and services.* • XI.EPSDT.2_CCHA Newsletter October 2021, pgs. 2-3	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 7: Exhibit B6—7.6.2.3, 12.8.3.4; 12.9.3.4	*CCHA's Behavioral Health Provider Manual includes information on EPSDT benefits and informs providers of training materials available through HCPF.* • XI.EPSDT.3_CCHA Behavioral Health Provider Manual, pgs. 30, 31 *CCHA's Physical Health Provider Manual includes information on EPSDT benefits and informs providers of training materials available through HCPF.* • XI.EPSDT.3_CCHA Physical Health Provider Manual, pgs. 28-31 *The following CCHA Provider Newsletter informed providers of the EPSDT benefit and linked to HCPF resources for EPSDT educational materials.* • XI.EPSDT.2_CCHA Newsletter October 2021, pgs. 2-3 *The February 2022 edition of the CCHA Provider Newsletter informed providers that CCHA produced an EPSDT recorded webinar and provided the link to view this educational resource on its website.* • XI.EPSDT.3_CCHA Newsletter February 2022, pgs. 1-2 • https://www.cchacares.com/for-providers/provider-resources-training	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following Special Bulletin email informed community partners of EPSDT benefits and how CCHA can help support members, provided links to HCPF resource materials, and shared the link to CCHA's recorded EPSDT educational webinar. • XI.EPSDT.3_CCHA Special EPSDT Bulletin, entire document *The following document is a template used to facilitate case reviews in collaboration with HCPF and other members of the care team, during which member needs are discussed, including services that may be covered under the EPSDT benefit.* • XI.EPSDT.1_CCHA Escalated Case Template Form, entire document	
4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). For the *Capitated Behavioral Health Benefit*, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it.	*The following document outlines CCHA's policy and procedure related to EPSDT, which includes the provision of all medically necessary behavioral health services for children under age 21 in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280.* • XI.EPSDT.1_CCHA_EPSDT Policy, pg. 5 *The following care coordination program descriptions outline care coordination activities for pediatric, foster care, and maternity populations, including that care coordinators will assist in arranging for the provision of all medically necessary services, and supports the*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	*member in accessing appropriate health screenings through qualified providers and in a manner that is culturally and linguistically sensitive to the member.* • XI.EPSDT.1_CCHA Program Description – Pediatrics - Foster Care, pgs. 4, 6 • XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 4, 6 *The following document outlines CCHA's policy regarding the provision of medically necessary services through using clinical criteria for utilization management decisions.* • XI.EPSDT.4_CCHA Clinical Criteria for Utilization Management Decisions Policy, entire document	
5. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services	*The following assessment is completed by care coordination and identifies member needs and referrals, including educational/vocational, transportation, family/caregiver, and social services such as WIC, SNAP, TANF, Prenatal Plus, etc.* • XI.EPSDT.5_CCHA Community Resources Referred Assessment, pgs. 4-6 *CCHA's Behavioral Health Provider Manual outlines that CCHA provides referral assistance, assistance*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.4.C	*with transportation, and makes use of other state health agencies and programs.* • XI.EPSDT.3_CCHA Behavioral Health Provider Manual, pg. 31 *CCHA's Physical Health Provider Manual outlines that CCHA provides referral assistance, assistance with transportation and makes use of other state health agencies and programs.* • XI.EPSDT.3_CCHA Physical Health Provider Manual, pgs. 30-31 *The following document serves as a CCHA member guide for Health First Colorado members and is available in English and Spanish. It includes information on how to contact CCHA, that CCHA can help with scheduling appointments, arranging transportation, and connecting members to other resources.* • XI.EPSDT.5_CCHA_Map_to_Medicaid_ENG, pgs. 1-2 • XI.EPSDT.5_CCHA_Map_to_Medicaid_SP, pgs. 1-2 *The following document informs members of the EPSDT benefit, that CCHA can help with scheduling appointments, and is available in English and Spanish.*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• XI.EPSDT.2_Well Child Insert_ENG, entire document • XI.EPSDT.2_Well Child Insert_SP, entire document *The following document serves as a quick reference guide to behavioral health and is available in English and Spanish. It includes information on how to contact CCHA and that CCHA can help with connecting members to needed resources, including transportation.* • XI.EPSDT.5_CCHA_BH Reference Guide_ENG, pg. 1-2 • XI.EPSDT.5_CCHA_BH Reference Guide_SP, pg. 1-2 *The following care coordination program descriptions outline care coordination activities for pediatric, foster care, and maternity populations, including that CCHA provides referral and transportation assistance as needed.* • XI.EPSDT.1_CCHA Program Description – Pediatrics - Foster Care, pg. 6 • XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 6-7 *CCHA developed the following document to help its staff understand the most current state agencies and*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	programs available and provides information on how to refer members. • XI.EPSDT.5_One Pager WIC-SNAP-NFP, entire document	
6. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational.	*The following document outlines CCHA's policy related to evaluating clinical criteria for utilization management decisions and includes the definition of medical necessity for EPSDT services.* • XI.EPSDT.4_CCHA_Clinical Criteria for Utilization Management Decisions Policy, pg. 2 *CCHA's Behavioral Health Provider Manual outlines the definition of medical necessity as it pertains to EPSDT benefits and services.* • XI.EPSDT.3_CCHA Behavioral Health Provider Manual, pgs. 31-32 *CCHA's Physical Health Provider Manual outlines the definition of medical necessity as it pertains to EPSDT benefits and services.* • XI.EPSDT.3_CCHA Physical Health Provider Manual, pg. 30	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not more costly than other equally effective treatment options. Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 7: Exhibit B6—14.5.7.1, 2.1.1	*The following document outlines CCHA's policy and procedure related to EPSDT, which includes the arrangement for the provision of all medically necessary behavioral health services for diagnoses listed in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses for children under the age of 21 in accordance with Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 and 1915(b)(3) Waiver services to members in at least the scope, amount and duration proposed in the Uniform Service Coding Standards (USCS) Manual. All 1915(b)(3) services provided to children/youth from age 0 to 21, except for respite and vocational rehabilitation, are included in the State Plan as EPSDT services.* • XI.EPSDT.1_CCHA_EPSDT Policy, pg. 7 *The following care coordination program descriptions outline care coordination activities for pediatric, foster care, and maternity populations, including that CCHA provides or arranges for vocational services, intensive case management, prevention/early intervention*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, and respite services. • XI.EPSDT.1_CCHA Program Description – Pediatrics - Foster Care, pg. 6 • XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 6-7 *The following assessment is completed by care coordination to identify member needs, including vocational services, and outlines referrals to behavioral health services.* • XI.EPSDT.5_CCHA Community Resources Referred Assessment, entire document *CCHA informs behavioral health providers of this requirement via the Provider Manual.* • XI.EPSDT.3_CCHA Behavioral Health Provider Manual, pg. 31 *The following MOU outlines CCHA's collaboration with the Department of Human Services in El Paso County, which includes roles and responsibilities, referral processes and identified a single point of contact for members who may be utilizing services that are covered under the Capitated Behavioral Health Benefit.*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• XI.EPSDT.7_El Paso County DHS MOU (R7), entire document • XI.EPSDT.7_El Paso County DHS MOU AMD (R7), entire document *The following tip sheet was developed in collaboration with the other RAEs to provide DHS entities across the state with consistent information on how the RAE can support Medicaid members. It includes language directing DHS staff to contact the RAE to help access EPSDT benefits and services.* • XI.EPSDT.7_RAE DHS Tip Sheet, pg. 1 *Daily integrated rounds are regularly attended by CCHA's chief clinical officer, utilization reviewers, and care coordinators. Caseworkers from the appropriate Department of Human Services and community mental health center (CMHC) are invited to attend as needed, and as permitted under HIPAA. Daily integrated rounds provide a platform to discuss challenging cases and for cross disciplinary teams to work together to develop treatment plans for members which include providing for and arranging EPSDT services and/or b3 services such as respite, assertive community treatment (ACT), residential treatment, and intensive case management.* *Additionally, CCHA has collaborated with CMHCs, SEPs, CCBs and county DHS to establish workflows*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and processes to streamline services for members, in order to avoid duplication and strengthen coordination of services. These processes allow CCHA and community partners to identify additional services needed to ensure the most positive outcome and experience for the member. Some of those services include intensive case management, residential care, assertive community treatment (ACT), respite services, and other outpatient services. See examples below. • XI.EPSDT.7_CCHA Complex Case Review Example (R7), entire document • XI.EPSDT.7_CCHA Care Conference Example 10.5.2021 (R7), entire document • XI.EPSDT.7_CCHA Care Conference Example 10.27.21 (R6), entire document	

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

Appendix B. Site Review Participants

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

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager III
Evarista Ogbon	Project Manager I
Lauren Gomez	Project Manager I
Crystal Brown	Project Coordinator III
CCHA Participants	**Title**
Abigail Roa	Compliance Officer
Amy Yutzy	Director, Medicaid Programs, Region 7
Andrea Skubal	Accountable Care Network Program Manager
Camila Joao	Clinical Quality Program Manager
Cara Hebert	Program Officer, Region 6
Cathy Herrera	Grievance & Appeals Audit Specialist
Cindi Terra	Manager, Quality & Practice Transformation
Clara Cabanis	Sr. Manager, Strategy & Performance
Colleen Daywalt	Manager, Marketing & Communications
Colleen McKinney	Director, Planning & Performance
Deb Munley	Senior Vice President, Quality & Clinical Programs
Diane Seifert	Network Manager, Region 7
Erica Kloehn	Regional Vice President, Provider Solutions
Jackie Ferguson	Director, Provider Experience
Jalesa Johnson	Administrative Assistant
Jessica Zaiger	Manager, Care Coordination, Region 7
Josie Dostie	Network Manager, Region 6
Kathryn Morrison	Director, Quality Improvement
Kelli Gill	Director, Behavioral Health/Utilization Management, Regions 6 and 7
Krista Newton	Director, Care Coordination
Laura Johnson	Manager, Care Coordination, Region 6
Leigh-Ann Rocha	Manager, Regulatory & Contracting

CCHA Participants	Title
Lizbeth Villaruz	Internal Audit Manager
Marianne Lynn	Compliance Manager
Marsha Penn	Utilization Management Lead
Megan Lujan	Medicaid Clinical Writer
Melanie Rylander, MD	Medical Director, Region 7
Michelle Blady	Manager, Behavioral Health Care Management, Regions 6 and 7
Patricia Payne, MD	Medical Director, Region 6
Ryan Wethington	Web Developer
Tiffany Lloyd	Manager, Utilization Management
Tony Olimpio	Manager, Member Support Services
Zula Solomon	Director, Quality & Clinical Programs
Department Observers	**Title**
Gina Robinson	Program Administrator
Lauren Staley	Program Specialist
Milena Guajardo	Program Specialist
Russell Kennedy	Quality and Compliance Specialist

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

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

Table C-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table C-2—FY 2021–2022 Corrective Action Plan for CCHA Region 6

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems.	CCHA documents clearly detailed internal CCHA care coordination procedures, program descriptions that contained outreach and monitoring expectations, and methods of communicating with entities involved in member care. However, a significant percentage of member care coordination occurred through ACN delegates. Delegated care coordination activities ranged from three tiers of care: 1) basic medical home models, 2) condition management, and 3) fully delegated to ACN. Although the delegate agreements contained a general statement about referral and collaboration expectations, the agreements did not detail expected mechanisms for the PCMP to inform CCHA about high-risk members or members for whom additional support is needed due to the PCMP not offering specific condition management programs. Staff member interviews indicated the PCMP may communicate with CCHA through email or may meet monthly or quarterly with CCHA care coordination staff to discuss high-risk members. However, the documentation did not clearly describe PCMP expectations regarding referral procedures or timelines.	CCHA must strengthen applicable documents and create a more detailed procedure that outlines referral procedures and timeliness expectations and how CCHA ensures that all member needs are addressed, regardless of auto-assignment into a particular PCMP tier or condition management capabilities.

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
• Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 7: Exhibit B6—11.3.1, 11.3.7		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written	The *Member and Provider Materials and Website* policy described procedures for ensuring that member informational materials contain taglines in large print (conspicuously visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation, the toll-free and TTY/TDD customer service numbers, and availability of materials in alternative formats. However, some critical member materials did not include all required components of a tagline. • The *Member Complaint Resolution Letter* had a tagline, but the tagline did not describe how to request auxiliary aids and services, including written translation or oral interpretation and that information is available in alternative formats upon member request at no cost. Additionally, the translated Spanish tagline was not in a conspicuously visible font size. • The *Notice of Adverse Benefit Determination* letter had a tagline, but the Spanish tagline did not include that, upon request, information is available at no cost to the member, and the English tagline did not include that information is available in alternative formats.	CCHA must revise critical member materials to include all required components of a tagline. HSAG recommends CCHA standardize the tagline across all critical informational materials.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3	• The *Map to Medicaid, Maternity Brochure*, *Foster Care Children & Caregiver Resources Member Guide Insert*, *Care Coordination Benefits Member Insert*, and *Well Child Insert* did not have a tagline in English and Spanish. • The EPSDT flyer had a tagline but did not include "no cost" to the member. The English copy did not have the tagline written in Spanish. • The taglines varied greatly across the documents submitted for review. Materials that are critical to obtaining services must include taglines, and the materials on this list contained critical information about CCHA members accessing care and understanding core programs that CCHA offers.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		

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

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	Staff members discussed the turnaround timelines for ad hoc requests for printed materials, provided screenshots of the Essette system where ad hoc requests could be documented, and provided email evidence that demonstrated an example of receiving and responding to such requests. For this example, staff mailed the requested materials within two days. However, the screenshot in Essette submitted as evidence stated that it "will take five to seven business days for the member to receive" the informational materials, further indicating a timely ad hoc printing and mailing process is not clear to staff members or documented in procedures. CCHA did not provide any supporting document regarding monitoring that ad hoc requests are printed and mailed to members within five business days.	CCHA must develop a mechanism to ensure that, upon request, members are provided with printed materials within five business days and at no cost.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
1. The RAE onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Academy of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation.	The *Early and Periodic Screening, Diagnostic and Treatment Colorado* policy described that outreach to foster care members occurred through the DHS case workers; however, CCHA reported issues with identifying this member population in two out of the four quarters in the review period, CY 2021. During the interview, CCHA could not confirm 1) the process in which DHS outreached members and did not have a monitoring mechanism to ensure outreach occurred, or 2) a long-term resolution for the foster care data issue. Additionally, CCHA did not outreach members who had not utilized services in the previous 12 months during three of the four quarters. Then in the last quarter of CY 2021, CCHA completed outreach to non-utilizers but noted an issue with data sorting procedures, which lead to inadvertently outreaching members who had utilized services in the previous 12-month period.	CCHA must develop a process to ensure access to foster data and outreach to newly eligible foster children is completed within 60 days of identification, either by DHS or CCHA. Due to CCHA implementing the outreach procedures for non-utilizers at the end of CY 2021, no required action is necessary. However, HSAG recommends revisiting quality assurance procedures regarding this data set.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
Contract Amendment 7: Exhibit B6—7.3.12.1, 7.6.2		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the RAE's key staff members to obtain a complete picture of the RAE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the RAE and the Department for review and comment. • HSAG incorporated the RAE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the RAE and the Department.