COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Site Review Report

for

Northeast Health Partners

Region 2

June 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

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

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	11	11	10	1	0	0	91%
IV. Member Rights and Protections	7	7	7	0	0	0	100%
V. Member Information	19	14	14	0	0	5	100%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	8	0	0	0	100%
Totals	**45**	**40**	**39**	**1**	**0**	**5**	**98%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

NHP provides care coordination activities for all members in Region 2 through delegated entities—Accountable Care Coordination Entities—which include the Federally Qualified Health Centers (FQHCs)—Peak Vista Community Health Centers (Peak Vista), Salud Family Health Centers (Salud), The Children's Health Place, Sunrise Community Health (Sunrise), and North Colorado Health Alliance (NCHA). NCHA provides care coordination services for members attributed to Sunrise and for all members with complex needs attributed to the non-FQHC primary care medical providers (PCMPs). Through this structure, 80 percent of the members in Region 2 receive care coordination services through NCHA. The Intensive Care Management team for Beacon Health Options (Beacon)—the administrative service organization (ASO) for **NHP**—may also provide support to delegated care coordinators and members with highly intense needs. **NHP**'s *Care Coordination Plan* described an overview of **NHP**'s comprehensive care coordination program, principles, processes, and overall organization. **NHP**'s *Care Coordination* policy described processes for member care coordination and addressed all care coordination requirements of the RAE contract. The *Primary Care Medical Provider Agreement,* executed with each accountable care coordination (CC) entity, designated the PCMP as the primary care case manager and delegated responsibility for the full list of care coordination requirements outlined in **NHP**'s *Care Coordination* policy. **NHP**'s *Population Health Plan* and staff members described **NHP**'s stratification methodology to identify members with high-risk, high-cost, and complex care coordination needs. Staff members noted that despite both Region 2 and Region 4 being highly rural populations, significant cultural differences which impact care coordination activities exist between the regions. Examples included: the highest costs of care in Region 2 are associated with pregnancy, while the highest costs in Region 4 are associated with diabetes; Region 2 has a high immigrant and refugee population in Weld County; and the Region 2 provider culture is highly collaborative in local communities in order to provide needed resources to members through the health neighborhoods.

While the Department's enrollment broker assigned each member to a designated PCMP, **NHP**'s engagement center—i.e., call center—also assisted members each, on request, to align with a behavioral health (BH) provider and/or change the designated PCMP; and informed members of the contact information for those providers. Accountable CC entity care coordinators outreached to members to link each to a BH provider if BH needs were identified in the diagnosis cost group (DCG) or population health stratification forwarded from Beacon to delegates. **NHP** provided a designated CC program phone number for all members, and CCs directly informed each individual member engaged in care coordination of his or her CC contact number.

NHP reviewed the Department's attribution list regularly and forwarded information to accountable CC entities; care coordinators followed up with each member who appeared to be attributed to an incorrect PCMP. Staff members reported that the enrollment broker has prohibited care coordinators from participating in a three-way call with the member and enrollment broker to change a member's designated PCMP; therefore, reattribution to a correct PCMP is dependent on the individual member's motivation to contact the enrollment broker.

Care coordination activities included assisting members with transitions of care between settings—including discharge planning from higher levels of care—and coordinating services with other RAEs, FFS providers, and community social support organizations. Care coordinators reported having an individual contact person at each RAE for conducting a warm hand-off and transition of records for members transitioning in and out of the RAE. Care coordinators also have a referral tracking system for FFS physical health referrals and conduct follow-up with providers and members. Accountable CC entities enabled seamless care coordination of PH and BH services through a variety of mechanisms, including: embedding BH care coordinators in PCMP locations; providing external BH providers with direct access to the PCMP's electronic health record (EHR), which includes care coordination activities; or conducting a warm hand-off and maintaining communication with other BH providers involved in the member's care. **NHP** documented that BH providers are required to perform an intake assessment and develop a related plan of care, with specifically defined documentation components. Beacon audits BH records to assess compliance with documentation requirements. **NHP** had also developed a comprehensive care coordination audit tool for assessing each delegated care coordination entity's compliance with delegated care coordination requirements. At the time of on-site review, this audit tool had been applied in NCHA and **NHP** was preparing to expand to all other delegates.

Care coordinators performed member needs assessments on all members and developed individual care plans as necessary, according to each member's needs and goals. Care coordinators shared assessments with other participants in the member's care, including BH providers, through the EHR or, for external providers without access to the EHR, through verbal communications or forwarding applicable sections of the comprehensive assessment according to an organization's need to know. **NHP** received results from the Department's health needs survey (HNS), Colorado overutilization program (COUP), and nurse advice line and forwarded the information to the appropriate delegated CC entity to inform member outreach and care coordination activities. Staff reported that fewer than 40 Department HNSs had been received since inception of the RAE contract and that information in the HNS was not actionable; however, **NHP**'s care coordinators performed a detailed assessment of member needs within a short time after enrollment. **NHP** policies, delegation agreements, and audit tools all addressed interventions for medical, behavioral, and non-medical needs. Care plans include deliberate provider interventions available to the broader population—e.g., provision of medical and social support referrals, educational resources, and maintaining telephonic and electronic communications. Care coordinator interventions for members with more complex needs include face-to-face visits with members; and arranging for and maintaining communications with diverse clinical providers—e.g., substance use providers, hospitals, pharmacists, dentists—and with transportation providers, numerous State and regional agencies, community resource providers, and other ancillary services.

Staff members described a unique collaborative care coordination environment throughout Region 2, with health neighborhood agencies and community organizations playing significant roles in care coordination. For example: NCHA is owned by an alliance of numerous Weld County agencies—including 13 member organizations and 72 partner organizations—which have been convening and collaborating around local, community-based healthcare initiatives for the past 10 to 15 years. The unique synergy of healthcare providers and organizations has enabled NCHA care coordinators and the RAE to be participants in and benefactors of these long-term relationships and commitments to Medicaid members. Staff members also described community-based multi-organizational groups,

organized through the county public health agencies, which coordinate resources needed by individual members. Regional care coordination meetings include the RAE CCs and all small community agencies and providers to identify what resources each community has to offer to members. Staff members stated that resources available throughout the region are easier to identify and gain access to through collaboration with the health neighborhood.

All RAE care plan activities are recorded in the delegate's EHR system. Staff members demonstrated Beacon's Connect 4 Care care coordination system used to collect and communicate *some* of the required components of the care coordination tool to the delegated accountable CC entities; however, each accountable CC entity maintained its own electronic care coordination system to complete the full care coordination tool for each member. HSAG reviewed the components of the electronic care coordination tool for two of the accountable CC entities and found the tools compliant with the required elements. In addition, NCHA's Light Beam care management software system demonstrated additional functionality—e.g., analytics, social support assessments, filtered care coordination notes, stratification of member risk based on the John Hopkins model to predict "ability to impact" member outcomes, acceptance of automated data feeds from multiple organizations, and sharing of system data with multiple providers. **NHP** maintained numerous policies and related documents that required providers and care coordinators to maintain confidentiality of member information in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and 42 CFR Part 2 drug and alcohol privacy regulations.

Summary of Findings Resulting in Opportunities for Improvement

NHP's Care Coordination Plan provides an overview of comprehensive care coordination services for RAE members and refers globally to services available for members through a variety of sources and processes. HSAG suggests that **NHP** consider enhancing its Care Coordination Plan to include more detailed description of its regionwide model for care coordination, such as a more definitive description of its delegated organizational model, alignment with PCMPs, configuration of CC teams, embedded care coordinators, care coordination record integration into EHRs, and access to care coordination information.

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

Summary of Required Actions

NHP demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining member health records in compliance with detailed documentation standards and for maintaining confidentiality and security of member health records. In addition, care compacts between individual referring and specialist providers—totaling 69 signed agreements at the time of on-site review—required sharing of clinical information between those specific providers. However, no other **NHP** documents clearly communicated expectations that all providers share member records with other providers or organizations involved with a member's care. **NHP** must enhance provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

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

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

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

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

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

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

Summary of Findings Resulting in Opportunities for Improvement

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

Members and providers were informed of the availability of language interpretation (including American Sign Language) through member handouts, MEAC and drop-in center meetings, and the Health First Colorado (HFC) member handbook; and for providers through the town hall trainings and the provider handbook. The provider handbook, however, states, "The regional organizational requires

providers to offer interpreter services for members who are deaf, speak a language other than English, or have other communication disabilities…." While assistance through **NHP**'s Office of Member and Family Affairs is offered, HSAG finds that this statement may be misinterpreted by providers, to mean that the cost responsibility is that of the provider. On-site, **NHP** staff members confirmed that all language line and in-person interpreter services are invoiced through the RAE; however, HSAG recommends that **NHP** consider clarifying language regarding interpreter services in the provider handbook so as not to deter providers from making any necessary arrangements.

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

Summary of Required Actions

HSAG identified no required actions related to this standard.

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

Summary of Strengths and Findings as Evidence of Compliance

NHP's EPSDT policy and procedure comprehensively addressed provision of EPSDT services for members ages 20 and under and outlined the requirements for providers to ensure that members receive well-child screening services through the PCMP and that BH practitioners provide mental health diagnostic and treatment services for EPSDT-eligible members when indicated by screenings. The RAE provider handbook included extensive information on EPSDT benefits and services, informed of assistance available through Healthy Communities (HC), and referred providers to HFC to obtain additional information. **NHP** BH and PCMP provider trainings described EPSDT as additional Medicaid benefits for members ages 20 and under. In addition, staff members stated that **NHP** had educated staff members in the DHS child welfare divisions in the region to promote EPSDT with members and exchanged information with child welfare staff regarding members' status of well-child visits. Community Mental Health Center (CMHC) staff stated that CMHCs are well-versed in EPSDT-related benefits and attentive to promoting primary care well-child visits and screenings with members. The provider handbook and provider documentation trainings included requirements for providers to document EPSDT screening results in the member medical record. **NHP**'s clinical record audit tool included review of medical records for documentation of EPSDT-related services and requirements for

members ages 20 and under. **NHP** informed members of EPSDT benefits through the **NHP** website and through various member "touchpoints" such as DHS child welfare staff; care coordinators; HC family health coordinators; PCMPs; CMHCs; and the Weld County Women, Infants, and Children's program.

Both the EPSDT and utilization management (UM) policies and procedures outlined the complete and accurate listing of EPSDT medical necessity criteria, and staff members stated that medical reviewers are familiar with the application of the expanded criteria for approving capitated EPSDT behavioral health benefits. UM staff arranged for provision of vocational services, clubhouse and drop-in centers, intensive case management, residential care, respite services, and other capitated or waiver behavioral health benefits as needed. **NHP** provided documentation to demonstrate that these services are available in the region, primarily through the CMHCs. UM staff members assisted providers with authorization requests for services not covered under the capitated benefits but covered by FFS. **NHP**'s Intensive Care Management team, PCMP care coordination teams, provider relations personnel, and call center staff all assisted members and providers with overcoming barriers to accessing EPSDT-related benefits when necessary—including transportation, referrals to HC, or initiating referrals to the HFC's Creative Solutions coordinator. **NHP** care coordinators described having established informal alliances with State and county agencies and community organizations in local areas of the region to enable referrals for individual members. Staff members provided examples of community-based multi-agency groups that come together to review individual complex cases and collaborate to fill gaps and provide resources for EPSDT-eligible members.

NHP has met with and provided education for HC contractors throughout the region and had executed one unified written agreement with the three DHSs which oversee HC coordinators in the 10 counties in the region; staff members stated that significant crossover in activities and communications existed among the three HC contractors in the region. **NHP** had executed separate business associate agreements (BAAs) with each of the three HC contractors.

NHP demonstrated overall attentiveness by providers, care coordinators, support staff, and local agencies and organizations for the provision of EPSDT benefits and services for members.

Summary of Findings Resulting in Opportunities for Improvement

While **NHP** had established a signed agreement with the three HC contractors, HSAG recommends that **NHP** consider delineating the specific activities performed by both the RAE and each HC contractor to ensure consistency or prevent gaps in processes performed by individual HC contractors to assist EPSDT-eligible members and families with accessing services.

During on-site interviews, staff members stated that EPSDT education for smaller BH independent practice network (IPN) providers was needed and that these providers were not adequately sharing information with PCMPs. In addition, HSAG noted the following opportunities for improvement in EPSDT provider trainings and materials: training presentations for providers included only high-level EPSDT information and were minimally attended by providers; the provider training tab on the **NHP** website included no information on EPSDT services and requirements; while the provider handbook included the most comprehensive description of EPSDT benefits, no provider communications directed

providers to the provider handbook for EPSDT information. HSAG recommends that **NHP** strengthen the content of provider trainings to thoroughly educate providers on EPSDT benefits, services, and requirements; and ensure that trainings or updates are available to all providers every six months. HSAG suggests that trainings and communications incorporate the need for all PCMPs and BH providers to share member-specific EPSDT information and refer providers to EPSDT information in the provider handbook.

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

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

Summary of Required Actions

HSAG identified no required actions related to this standard.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

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

Compliance Monitoring Site Review Methodology

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

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

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

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

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

Objective of the Site Review

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

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

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit*, the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities.	**Documents Submitted/ Location Within Documents:** 1. 262L_ CareCoordination_2RAE-entire policy 2. CareCoordinationPlan_2RAE-entire doc 3. QM 33F_RAE_CulturalCompetency_2RAE-entire doc 4. Care CoordinationInternalAuditTool-2RAE-entire doc 5. ProviderHandbook_2RAE-page 29; 33-35*misc. 6. PCMPFullAccountableAgreement_2RAE-pages 19-23*misc. 7. PopHealthManagementPlan_NHP-entire doc **Description of Process:** The RAE implements procedures to deliver care to and coordinate services for all members, and demonstrates this in the following documents: PopHealthManagementPlan_NHP: The population health plan supports care coordination at the place of care and/or from an existing trusted and local provider, as a critical intervention that is available to all Members in Region 2. Care Coordination is an intervention that connects our Members and engages them in the resources available is a key intervention to managing our population's health overall. Members are stratified based upon both physical health and behavioral health diagnosis and utilization criteria. Diagnostic Cost Groupers (DCG) provided by Truven and the number of chronic conditions measures the physical health risk. Mental Health Diagnosis, Substance Use Diagnosis (SUD), number of inpatient admissions, emergency room visits and SMI designation are the criteria used to determine behavioral health risk. In addition to the prescribed four quadrants, we have broken out the quadrants into six physical health	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit B1—11.3.1, 11.3.7	and six behavioral health categories. The additional categories will allow for more specific evaluation and ability to identify members moving along the stratification continuum. We used the DCG Range values provided by Truven and split the moderate risk score out into two categories, "Low Moderate" and "High Moderate" we also did the same for the behavioral health continuum. Within the received Truven data, we will also be utilizing the provided ED Visit Risk score to identify members who are at risk for changing stratification. Members who qualify for the Client Over Utilization Program (COUP), will be placed in the Low Moderate category to start, however this may be increased based upon the number of admissions and/or ED visits they have. 262L_ CareCoordination_2RAE adheres to this requirement and identifies the Accountable Care Coordination Entity is responsible for coordinating all aspects of the Members care, including the medical treatment team, specialty care and any other health providers involved in the Member's care. Care coordination provided at the point of care whenever possible, is culturally responsive and provided for both short and long-term healthcare needs. Member preferences are respected and regular communication between care coordinators and the practitioners delivering services to Members provided. This policy addresses all components of this requirement, including that it: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. CareCoordinationPlan_2RAE addresses this requirement specifically and the entire plan is applicable. This plan provides an overview of comprehensive care coordination services for members of the Regional Accountable Entity (RAE). This plan is intended to provide guidance about the scope of care coordination activities, yet it must be acknowledged that the service needs for individual members can vary widely and the specific processes for care coordination may vary, depending upon the type of treatment setting and the staff that are assigned care coordination responsibilities. Members may receive care coordination services through the RAE, or through its partners/providers. Service settings may include individual primary care practices, group medical practices, specialty care settings, behavioral health care settings, including community mental health centers, Federally Qualified Health Centers, and other locations. The RAE works to provide education, monitoring, reporting, training, and communication. QM 33F_RAE_CulturalCompetency_2RAE underscores the commitment to developing and implementing policies and procedures that will enhance cultural competency; to breaking down barriers to access and utilization that are faced by many minorities when seeking	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	behavioral health care. These barriers include relevancy of services and financial, language, transportation and literacy barriers; to broadening multi-cultural participation in our provider network; to promoting the ethic of cultural competence and educating our staff, providers, partners, Members and the community about Member's rights to culturally competent services. **The Provider Handbook**: Cultural Competency Section page 29 identifies that the regional organization requires all physical, behavioral health and care coordination services are provided in a culturally competent manner. This includes sensitivity to the member's particular language needs and their cultural beliefs and values. **Care Coordination Section pgs. 33-35** identifies expectations for providers as it relates to Care Coordination, regional strategy, the care coordination delegation model, provider role as it relates to care coordination and care coordination principles. We work to improve care coordinators knowledge through ongoing trainings/meetings regarding contract requirements. Additionally, providers will be monitored on compliance with this requirement through existing audit procedures. See Care CoordinationInternalAuditTool-2RAE	
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member.	**Documents Submitted/Location Within Documents:** 1. 262L_ CareCoordination_2RAE-entire policy 2. CareCoordinationPlan_2RAE-page 5 3. ClinicalAuditTool_2RAE-Section E 4. Care CoordinationInternalAuditTool-2RAE-Section B 5. CareCoordinationWelcomeLetter_NHP-entire doc 6. ProviderHandbook_2RAE-page 26; 33-35 & 71-72 *misc. 7. 210L-Routine Member Requests_2RAE-entire doc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit B1—None	8. WellPass_2RAE –entire doc 9. WellpassHealthPlanCampaignTemplate_2RAE-entire doc **Description of Process:** *We initiate this process internally by providing each of the care coordination entities in Regions 2 with a list of designated Members attributed to them. The member's "MemberID" (Medicaid ID) is bumped up to the 834 member eligibility dataset to confirm that the member is eligible within the RAE. Once complete, a set of queries assigns a Care Coordinator to the members based off of PCP location. The reports are then sent out to the Care Coordinators via secure email or through FileConnect. We also provide care coordination information to Members on the Website & have a designated CC phone number.* 262L_ CareCoordination_2RAE addresses this requirement specifically. The entire policy is applicable. It identifies that the Accountable Care Coordination Entity is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. The care coordinator will share the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste and abuse. CareCoordinationPlan_2RAE-page 5 speaks to Care Coordination being delegate to specific staff person with appropriate	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	knowledge/training to function as the single point of contact with the different systems and settings related to the Member. The Provider Handbook-page 26 encourages *participating behavioral health providers* to communicate with *members* to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by Beacon or a designee of Beacon; page 33-35 identifies the participating provider role in care coordination. Providers are monitored on compliance with this requirement through existing audit procedures. See ClinicalAuditTool_2RAE—Section E. Care Coordination Delegated Entities are monitored on compliance with this requirement through existing audit procedures. See Care CoordinationInternalAuditTool-2RAE-Section B. Members are sent a *Welcome Letter* from their Attributed Provider/Delegated Care Coordination entity. Please see CareCoordinationWelcomeLetter_NHP Beacon Health Options care management team also conducts coordination of care activities in the following situations (See Provider Manual, Page 71-72): Members and participating behavioral health providers may access the Beacon care management system through any of the following avenues: ☐ 24-hour toll-free emergency care/clinical referral line ☐ Direct registration/certification of care through ProviderConnect for participating providers	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	☐ Direct registration of care through the Interactive Voice Response (IVR) system (in those local Beacon Engagement Centers where IVR is used) ☐ Direct authorization/certification of all levels of care through referral by a Beacon CCM ☐ Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms, or crisis response teams If a call is received from a member requesting a referral and/or information about participating behavioral health providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating behavioral health providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating behavioral health providers holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location, and phone number of at least three participating behavioral health providers will be given to the member. The provider manual also captures CCM review process to determine that the appropriate LOC is being provided. 210L-Routine Member Requests_2RAE entire policy. All member requests are handled expeditiously. Each member attempting to access care directly or by a representative through any Beacon Health Options 24 hour Clinical Referral/Direct line is assessed for risk of self-harm, harm to others, or harm by others and referred to the appropriate level of care. The Members is given information related to Network	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Providers/Care Coordination Entities including providers' names, addresses and phone numbers in attempt to link with services. Wellpass_2RAE document outlines the secure, HIPAA-compliant messaging platform that sends text alerts/campaigns to Members, including a "welcome to the RAE" onboarding text, outlining resources including access to care coordination with instructions on how to contact the RAE and/or care coordinator. The Wellpass platform supports text messaging, secure inbox messages, email and automated calls, and allows health plans to enroll members in evidence-based health, wellness and condition-specific messaging programs; Create custom messaging programs to meet specific plan goals; Message an entire population (broadcast) or communicate with individual members (person-to-person). WellpassHealthPlanCampaignTemplate_2RAE outlines text bank examples: • Did you know that Health First Colorado pays for most mental health and substance use treatment? For a referral call 1-888-502-4185 or visit https://www.northeasthealthpartners.org/	
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	**Documents Submitted/Location Within Documents:** 1. AttributionClaimsDataValidationProcess_2RAE-entire doc 2. PR-101A_PCMPProviderContracts_2RAE-entire doc 3. PR-101B_PCMPProviderContracts_2RAE-entire doc **Description of Process:** *The RAE compares the Department's attribution and assignment list with Member claims activities to ensure accurate attribution/assignment. The RAE also completes follow-up with*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
assist the member in changing the attributed PCMP. Contract Amendment 1: Exhibit B1—6.8.1	*Members to identify barriers accessing PCMP's within the region and assist with changing the attributed PCMP when appropriate. This is demonstrated in the following processes:* AttributionClaimsDataValidationProcess_2RAE: the entire document outlines the standard operating procedure to verify the attribution list provided by the Department of Health Care Policy and Finance (HCPF) is aligned with claims activity to ensure Members are being assigned to providers in which they have an active relationship with. This process is intended to ensure that this alignment exists in the attribution files provided by HCPF. *Once this process is complete, we provide the list of outliers to the care coordination entities for follow-up to assess for any barriers, as well as to assist with contacting the enrollment broker for reattribution.* PR-101A_PCMPProviderContracts_2RAE entire policy focuses on establishing the process for data entry and maintenance of Primary Care Providers (PCP) in multiple systems to ensure accuracy for Provider Directory, Network Adequacy and other client/regulatory needs. This SOP is for new PCP executed contracts to add contract and all supporting documentation for the Connects Systems and PCP Database. PR-101B_PCMPProviderContracts_2RAE entire policy focuses on establishing the process for data entry and maintenance of Primary Care Providers (PCP) in multiple systems to ensure accuracy for Provider Directory, Network Adequacy and other client/regulatory needs. This SOP is for making any changes, updates or deletions of information for contracted Primary Care Providers.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Provider Relations Department ensures all contracted PCMPs by Billing ID are affiliated with the RAE, make any additions, changes or deletes on monthly basis as appropriate. This includes closing or opening panels for new members or geo attribution. Works with internal data analysts to confirm the correct PCMPs by Billing ID when KMR conducts a crosscheck of the attribution and assignment to identify any peculiar attribution (i.e. a non-contracted PCMP has attributed members). Works with PCMP's if they report issues with attribution and forward to HCPF for panel analysis and resolution. This can include PCMP reporting members with claims history not being attributed to them.	
4. The RAE ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit B1—11.3.3.2	**Documents Submitted/ Location Within Documents:** 1. 262L_ CareCoordination_2RAE-Pages 2-3 2. CareCoordinationPlan_2RAE-Pages 4-5 3. Care CoordinationInternalAuditTool-2RAE-Sections A&B **Description of Process:** *The RAE ensures care coordination that includes deliberate interventions for short-term care coordination needs as well as extended interventions that encompass ongoing or long-term care coordination needs by a designated care coordinator.* 262L_ CareCoordination_2RAE -pages 2-3 reflects expectations that the Care Coordinator will coordinate services and share relevant treatment information identified groups or parties, as appropriate to ensure collaboration of care. Care coordination will be accessible to all Members. Care coordination is comprised of deliberate interventions as well as extended care coordination. Deliberate interventions are available to the broader population and include tactics such as medical	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and social referrals, telephonic/electronic communications, educational resources, etc. Extended care coordination is targeted to specific member groups who require more intense and prolonged assistance and includes interventions such as care planning, face-to-face visits, etc. CareCoordinationPlan_2RAE outlines that Care Coordinators shall maintain relationships with community organizations such as specialty care, managed service organizations and their networks of substance use providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers. Develop and maintain comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations. Care Coordination will delegate to specific staff person to function as the single point of contact with the different systems and settings related to the Member. A designated staff person is identified and will have the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population. CareCoordinationInternalAuditTool-2RAE –Sections A&B addresses both short and long-term health needs. Ensures care coordination documentation for developing and maintaining comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including: medical	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations. Care Coordination documentation for linking members to both medical and non-medical, community-based services, such as child care, food assistance, elder support services, housing, utilities assistance, and other non-medical supports. Shows proof of delegating care coordination duties to designated staff persons to function as the single point of contact with the different systems and settings related to the Member; Designating staff persons have the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population; Are providing specific guidance to care coordinators about each setting, regarding how to identify Members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and Member concerns.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit B1—14.3, 11.3.10, 11.3.5, 10.3.2, 10.3.4	**Documents Submitted/Location Within Documents:** 1. 282L_TransitionsofCare_2RAE –entire policy 2. CareCoordinationPlan_2RAE-Pages 2, 4 3. Care CoordinationInternalAuditTool-2RAE-Sections A, B, D and P10-P14 **Description of Process:** *The RAE administers the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the Work outlined in the Contract thereby creating a seamless experience for Members and Providers, evidenced by:* 282L_TransitionsofCare_2RAE addresses this requirement specifically. The entire policy is applicable as the focus centers on assisting Members in transition, from one system of care to another with minimal disruption in their behavioral health services. The current behavioral health system of care in Colorado is complex and sometimes fragmented by varying payment streams, eligibility requirements, and benefits. Members may need assistance in navigating this complex landscape to achieve optimal health outcomes. CareCoordinationPlan_2RAE outlines that Care Coordinators shall assist to members who are transitioning between health care settings and populations served by multiple systems, including, but not limited to, children involved with child welfare, Health First Colorado-eligible individuals transitioning out of the criminal justice system, Members receiving LTSS services, and Members transitioning out of institutional settings. ***This policy also outlines that Care Coordination will be accessible to all Members.***	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CareCoordinationInternalAuditTool-2RAE –Sections A, B, D and P10-P14 address this standard. Beacon Health Options will be auditing the Care Coordination Entity to ensure coordinated transitions of care in the following situations: transitions of Members from one RAE to another RAE when Members are actively engaged in Care Coordination and/or receiving covered services through the Capitated Behavioral Health Benefit; transitions of Members from institutional settings to community-based services; transitions of Members from in-patient hospital stays to the community; Medicaid-eligible Members transitioning out of the criminal justice system and children involved with Child Welfare. This audit tool also outlines the expectation of maintaining relationships with community organizations such as specialty care, managed service organizations and their networks of substance use disorder providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers. As well as developing and maintaining comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including: medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations to ***ensure coordination of care/transitions of care for all Members.***	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit B1—7.5.2–3	**Documents Submitted/Location Within Documents:** 1. EDI_HealthNeedsSurvey_2RAE- entire document 2. 262L_ CareCoordination_2RAE-Page 4 3. CareCoordinationPlan_2RAE-Page 6 4. PCMPFullAccountableAgreement_2RAE-page 23 *misc. 5. Care CoordinationInternalAuditTool-2RAE-Section P16 **Description of Process:** *The RAE uses the results of the Health Needs Survey, provided by the Department, to inform Member outreach and Care Coordination activities. The RAE processes a daily data transfer from the Department to retrieve the HNS results for distribution to attributed care coordination entities. This drives member outreach and care coordination activities.* EDI_HealthNeedsSurvey_2RAE: **Process**-The FUBS Application runs on an automated schedule to download the Health Needs Surveys. FUBS will look for any new HNS that are made available on the SFTP site. Once FUBS finds a new file, the file is downloaded to a file repository on the server. The file is then processed to the Colorado data warehouse under the [RAE2]. [Dbo]. [HealthNeedsSurvey] database structure. All Health Needs Surveys are appended to this database. **Reviewing Heath Needs Survey Data Set** The member's "MemberID" (Medicaid ID) in the HNS is bumped up to the 834 member eligibility dataset to confirm that the member is eligible within the RAE. The HNS does not have the member demographics such as phone and address. This information is pulled	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	from the 834 member eligibility dataset and is appended to the HNS database. Once the member's demographics have been included in the HNS dataset, a set of queries assign a Care Coordinator to the members based off of PCP location. The reports are then sent out to the Care Coordinators via secure email or through FileConnect. 262L_ CareCoordination_2RAE -page 4, CareCoordinationPlan_2RAE-page 6 and PCMPFullAccountableAgreement_2RAE-page 23 all reinforce expectations for the Care Coordination entity to use the results of the Health Needs Survey, COUP and Nurse Advice Line, provided by the Department, to inform Member outreach and Care Coordination activities. Care CoordinationInternalAuditTool-2RAE-Section P16 identifies in the audit tool where this requirement is being assessed/monitored.	
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit B1—14.7.1.1-2	**Documents Submitted/Location Within Documents:** 1. ProviderHandbook_2RAE-page 68 *misc. 2. QM 16B_Provider Treatment Record Review_Analysis_Reporting_COS_ EC_2RAE- entire document 3. QM 319.04_2RAE-entire policy 4. 223L_Treatment Planning_CI_2RAE-entire policy 5. ClinicalAuditTool_2RAE-Sections B + C 6. DocumentationTraining_2RAE- entire document 7. SignInSheet_DocumentationTraining_2019Jan09_2RAE-entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: *Based on the Member's needs and level of care required, the RAE ensures procedures for the following: each Member receives an individual intake and assessment appropriate for the level of care needed, and a service planning system that uses the information gathered in the Member's intake and assessment to build a service plan.* ProviderHandbook_2RAE-page 68: **Behavioral health providers/participating behavioral health providers** must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. CCMs review the treatment plans with the behavioral health providers/participating behavioral health providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum: ☐ Specific measurable goals and objectives ☐ Reflect the use of relevant therapies ☐ Show appropriate involvement of pertinent community agencies ☐ Demonstrate discharge planning from the time of admission ☐ Reflect active involvement of the member and significant others as appropriate Behavioral health providers/participating behavioral health providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	QM 319.04_2RAE: the entire policy covers expectations for Providers related to assessment/treatment planning. Record Reviews are conducted to ensure providers are following best practices in treatment plan development that reflects the Members individual treatment needs. The review is focused on adherence to clinical practice guidelines, use of appropriate measurement based tools, compliance with medical necessity criteria, expedient and flexible treatment planning based on on-going assessments, and discharge planning that begins upon initial assessment and/or admission to a service. Beacon prioritizes treatment record reviews based on contractual obligations and regulatory requirements. QM16B_ProviderTreatmentRecordReviewAnalysisReportingCOS EC_2RAE: entire policy covers review of behavioral health practitioner treatment records to evaluate compliance with the treatment record documentation standards and to monitor adherence to clinical practice guidelines adopted by COS_EC, as part of continuous quality improvement and/or monitoring activity. All COS_EC providers are required to maintain records in compliance with COS_EC, and the State of Colorado standards, which require that "member treatment records are maintained in a manner and includes current, comprehensive, detailed, organized, and legible writing and/or electronic organization to promote effective member-care and quality record review process". Treatment records are subject to audit/reviews by the State of Colorado, COS_EC's Clinical and/or Quality Management/Compliance Departments and accrediting bodies. Provider participation is an integral part of COS_EC's quality improvement program and is a condition of network participation. Policy 223L_Treatment Planning_CI_2RAE-entire policy identifies that that our providers are required to develop treatment plans that are	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	based on data from an individualized assessment and our chart review process will evaluate compliance with this requirement. Providers are monitored on compliance with this requirement through existing audit procedures see ClinicalAuditTool_2RAE-Sections B + C-the auditing focus as it relates to intake assessment and treatment planning requirements and are provided training outlined in the document: DocumentationTraining_2RAE.	
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the Member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit B1—None	**Documents Submitted/Location Within Documents:** 1. CareCoordinationPlan_2RAE-Pages 2,4,6 2. 262L_ CareCoordination_2RAE -Page 2 3. Care CoordinationInternalAuditTool-2RAE-Sections B, D, Procedures and P15 4. Compact_Criteria Tool_2RAE-entire doc 5. SAMPLE1_CareCompact_MOU_2RAE-entire doc 6. SAMPLE2_BH CareCompacts_2RAE-entire doc 7. Peak Vista Community Health Centers - Agreement_NHP-entire doc 8. the childrens place_abe_Holly May Care Compact, 1-3-2019_NHP-entire doc **Description of Process:** *The RAE has established and strengthened relationships among Network Providers and the Health Neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.* The CareCoordinationPlan_2RAE captures that care coordinators will reach out and connect with other service providers. The goal is to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	communicate information appropriately, consistently, and without delay. The ASO will ensure that all care coordination, including interventions provided by Network Providers and Subcontractors meet the needs of the Member. Beacon will provide additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction. 262L_ CareCoordination_2RAE -page 2 addresses this requirement specifically. It identifies that the Accountable Care Coordination Entity is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. The care coordinator will share the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste and abuse. Providers are monitored on compliance with this requirement through existing audit procedures see Care CoordinationInternalAuditTool-2RAE- Sections B, D, Procedures and P15 Compact_Criteria Tool_2RAE entire doc-contains Practice information for all practices entering the agreement, initiated or reviewed in the last 12 months and identifies clear expectations **for both primary / specialty care practices**. SAMPLE1_CareCompact_MOU_2RAE entire doc outlines The purpose of this MEMORANDUM OF UNDERSTANDING (MOU)/Care Compact (CC) is to establish a mutual agreement for	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	cooperatively providing medical services as maybe necessary for the health care of patients between specialist and PCP. The MOU outlines mutual interest and benefit to work cooperatively in the provision of services and structures how each will work to establish and define the processes and procedures in the provision of services between the parties. SAMPLE2_BH CareCompacts_2RAE entire doc outlines The purpose of this MEMORANDUM OF UNDERSTANDING (MOU)/Care Compact (CC) specifically related to behavioral health. This MOU outlines mutual interest and benefit to work cooperatively in the provision of services and structures how each will work to establish and define the processes and procedures in the provision of services between the parties. It serves as a care compact for establishing clear guidelines for the referral, treatment and effective co-management of patients who are receiving or would benefit from receiving care through both agencies. Both parties agree to work collaboratively for coordination of care for any patients shared in this relationship. Peak Vista Community Health Centers - Agreement_NHP-entire doc example of specialty care/care compact. The childrens place_abe_Holly May Care Compact, 1-3-2019_NHP-entire doc example of specialty care/care compact.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing Services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	**Documents Submitted/Location Within Documents:** 1. Q4.04_Provider Performance Monitoring_2RAE- entire document 2. Q2.04_RolesResponsibilityQualityImprovCommittee_2RAE- entire document 3. QM 16A_ProviderTreatmentRecord_AttachmentA_2RAE- entire document 4. QM 16B_ProviderTreatmentRecord_AttachmentB_2RAE- entire document 5. 33.4_UsesandDisclosureofPHI_2RAE-entire policy*misc. 6. Providerhandbook-2RAE-pages 18-19*misc. 7. HIPAAPrivacy_NHP, page 1 *misc. 8. HIPAASecurity_NHP, entire document *misc. 9. HIPAA_NHP, entire document *misc. 10. Beacon Health Options Practitioner Participation Agreement_2_RAE-page 3 sections 1.9, 9.6 and 9.7 **Description of Process:** *As the administrator of a capitated benefit, the RAE employs strategic health care management practices in administering the benefit and creates financial incentives to drive quality care and strong Member experience protections.* Q4.04_Provider Performance Monitoring_2RAE entire policy outlines expectations related to maintaining health records in accordance to professional standards. Q2.04_RolesResponsibilityQualityImprovCommittee_2RAE entire policy. This policy monitors compliance, as applicable, with	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	organizational requirements, accrediting organizations, the State of Colorado, and other regulatory agency requirements. QM 16A_ProviderTreatmentRecord_2RAE: This document highlights the Treatment Record Documentation Audit, Treatment Record Review Methodology/ Engagement Center's selection methods for programs/facilities as well as Guidelines for Provider Follow-Up. QM 16B_ProviderTreatmentRecord_2RAE: Attachment B offers Guidelines for Treatment Record Compliance Audit Follow-up Actions. 33.5_UsesandDisclosure of PHI_2RAE and Providerhandbook-2RAE addresses the requirements of providers to protect the confidentiality, privacy, and security of identifiable health information. NHP follows the following policies: HIPAA Privacy states on page one (1) that NHP will ensure the privacy of an individual's health and personal information as requirement by federal and state regulations. HIPAA Security outlines how NHP will protect Members' PHI; HIPAA_NHP outlines that NHP will designate a Privacy Office to ensure Member's privacy. Beacon Health Options Practitioner Participation Agreement_2_RAE details the agreement that is entered into between Beacon Health Options and contracted providers. Section 1.9 defines HIPAA and sections 9.6 and 9.7 informs providers that that they will agree to maintain and share member records in a HIPAA compliant manner	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: NHP demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining member health records in compliance with detailed documentation standards and for maintaining confidentiality and security of member health records. In addition, care compacts between individual referring and specialist providers—totaling 69 signed agreements at the time of on-site review—required sharing of clinical information between those specific providers. However, no other NHP documents clearly communicated expectations that all providers share member records with other providers or organizations involved with a member's care.		
Required Actions: NHP must enhance provider communications regarding the requirement that each provider furnishing services to the member share, as appropriate, the member health record with other providers or organizations involved in the member's care.		
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the	**Documents Submitted/Location Within Documents:** 1. Connect4Care_Screenshots_2RAE-entire document **Description of Process:** *The RAE possesses and maintains an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. Connect 4 Care is Beacon's Care Coordination tool – Connect 4 Care collects the following data sets to support communication and coordination among members of the provider network and health neighborhood.* -834 Member Eligibility data -CORHIO ADT data -Nurse Advice Line data -Health Needs Survey data -Daily Census -COUP data Connect 4 Care aggregates the data sets above to create one "Member Summary Report" (MSR). The MSR will always display the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Change in medication prescribed Referral to Specialist Cancelled Appointment with no reschedule No Show for Appointment Referral to ER Crisis Intervention (Behavioral) Called for ambulance to transport to ER **Hospital Encounter** Hospital Discharge Hospital Admission ER Visit ER Visit (Unattributed Member) Authorized Inpatient Stay **Assessment Tools** The Geriatric Depression Scale (GDS) Patient Health Questionnaire (PHQ-9) Edinburgh Postnatal Depression Scale (EPDS)	
11. The RAE ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(6)* Contract: 20.B	**Documents Submitted/Location Within Documents:** 1. Beacon_InfoSecurityBrochure_2RAE- entire document 2. 262L_CareCoordinationPolicy_ 2RAE-Pages 4-5 3. ClinicalAuditTool_2RAE-Section A 4. Care CoordinationInternalAuditTool-2RAE-Section-P18 5. QM 319.04_2RAE-entire policy **Description of Process:** *Beacon Information security practices follows industry best practices and compliance framework based on HIPAA, HITRUST, NIST and the*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Amendment 1: Exhibit B1—11.3.7.11, 15.2.1.2.2	*ISO 27001:2013 standard. Beacon Health Options (National) undergoes stringent audits like Type II SOC1, Type II SOC2, Verizon Business/Cybertrust Security Management Program and accreditation programs such as NCQA, URAC, and MOS DIACAP/RMF.* Beacon_InfoSecurityBrochure_2RAE outlines rigorous security measures inherent in the design, implementation, and day-to-day operations of Beacon as part of our continuing commitment to security of information and HIPAA compliance. This document is intended to provide a glimpse into the world of Information security within Beacon in a day-today environment and help assuage questions related to security, compliance, privacy and business continuity. 262L_ CareCoordination_2RAE -pages 4-5 reflects expectations that Beacon Health Options will coordinate services and share relevant treatment information identified groups or parties, as appropriate to ensure collaboration of care and ensuring that all communications with other providers are in accord with all applicable Federal and State requirements related to the protection of individually identifiable health information. These requirements include those specifically identified in 45 CFR, parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. Providers are monitored on compliance with this requirement through existing audit procedures see ClinicalAuditTool_2RAE-Section A and through Care CoordinationInternalAuditTool-2RAE-Section-P18 QM 319.04_2RAE policy outlines that all network practitioners are required to maintain records in compliance with, accrediting, and regulatory body standards, which require that member treatment	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	records are maintained in a secure manner and includes current, comprehensive, detailed, organized, and legible writing and/or electronic organization to promote effective member care and reflect acceptable standards during the quality record review process. Treatment records are subject to audit/reviews.	

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

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit B1—7.3.7.1–2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE – Entire Policy **Description of Process:** NHP adheres to our Member Rights and Responsibilities Policy, (see 304LMemberRandRPolicy_2RAE) guides our position on protecting member rights. The Members Rights and Responsibilities policy meets all state and federal regulations and contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit B1—7.3.7.3	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE (page 10) 2. Employee AttestationofMemberRights_2RAE- entire document 3. ProviderContract_2RAE, pages 13, 22 4. Feedback Database_NHP, page 2 5. ProviderHandbook_2RAE, page 17 *misc. 6. TownHall_NHP, page 6 *misc. 7. TownHallSigninsheets_NHP, entire document *misc. **Description of Process:** NHP follows Beacon's Member Rights and Responsibilities Policy and requests that employees read and sign a copy of the policy (see page 10 of 304_Member RandRPolicy_2RAE. For examples of signed attestations, see Employee Attestation of MemberRights_2RAE. Employees attest that they have read the Members Rights and Responsibilities policy and that they are expected to treat Members in a manner that respects their rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	If a Member believes that their rights have been violated, they can make a complaint at any time by phone, letter, in person, or an email. A complaint is monitored through the complaints process. There is a complaint category that is specific to a violation of Member Rights (see Feedback Database_NHP, page 2). There is a non-discrimination notice alerting Members that the RAE follows applicable federal and state laws on our website. (see Northeast Health Partners website) The RAE has information about Member Rights and Responsibilities in the Provider Handbook (see page 17). There is a description in the Providers Contract that they will comply with state and federal laws relating to Member's confidentiality rights (See ProviderContract_2RAE, pages 13 and 22). The RAE hosts town halls and educates providers on Member Rights and Responsibilities. See Town Hall_NHP and TownHallSigninSheets_NHP.	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy.	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE, pages 1-33 2. 307L_MemberInfoReqPolicy_2RAE, page 2 *misc. **Description of Process:** Northeast Health Partners follows Beacon's policies and procedures to ensure that each Member is guaranteed rights. See highlighted portions of 304LMemberRandRPolicy_2RAE, pages 1-3.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit B1—7.3.7.2.1–6	NHP follows the Member Information Requirements Policy and Procedures to ensure that Members are given information in accordance with the requirements stated in 42 CFR438.10. See 307LMemberInfoReqPolicy_2RAE, page 2.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit B1—7.3.7.2.7	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_2RAE, page 2 2. ProviderHandbook_2RAE, page 19 *misc. 3. IceCreamandInfo_NHP, entire document *misc. 4. MemberRightsWorkSheet_NHP, entire document 5. IceCreamandInfoRoster_NHP, entire document 6. Complaint Guide_NHP, page 2 7. RightsandResponsibilitiesPoster_NHP, entire document 8. RightsandResponsibilitiesPosterSpanish_NHP, entire document **Description of Process:** Northeast Health Partners delegates the oversight of this requirement to Beacon Health Options. Beacon's Member Services Department is responsible to uphold member rights without retaliation to the Member. This is done through member and provider education and through the complaint process. Northeast Health Partners follows Beacon's Member Rights and Responsibilities Policy to ensure that each member is free to exercise their rights and that they will not be treated adversely by the RAE, network providers, or the state Medicaid agency (Healthcare, Policy, and Financing). See 304LMemberRandRPolicy_2RAE. The ProviderHandbook_2RAE outlines on page 19 that Members will not lose their Health First Colorado benefits for filing a complaint nor be treated differently for filing a complaint, nor be restricted access to services. See	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members are made aware of their rights and responsibilities through several avenues. There is a Rights and Responsibilities document on our website (see Rights and Responsibilities Document). In this document, the ninth item is "Use your rights and or file a complaint without fear of being treated poorly." This document is available in both English and Spanish on NHP's website (see Rights and Responsibilities). Member Rights and Responsibilities posters and How to File a Complaint posters are distributed at partner sites, provider's offices, and at the RAE in both English and Spanish. See Rights and Responsibilities Poster_NHP and Rights and Responsibilities Poster Spanish_NHP. Northeast Health Partners also host Lunch and Learns for Members to educate them on their rights and responsibilities. Please see IceCreamandInfo_NHP flyer, MemberRightsWorkSheet_NHP, and IceCreamandInfoRoster_NHP. There is a complaint guide on the website (see Northeast Health Partners website) which explains that Members will not be treated differently for making a complaint (i.e., exercising their rights). This is available in both English and Spanish. Please see Complaint Guide_NHP page 2.	
5. The RAE complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of	**Documents Submitted/Location Within Documents:** 1. 310L_NonDiscriminationPolicy_2RAE, page 1 2. 304L_MemberRandRPolicy_2RAE, page 5 3. Feedback Database_NHP, page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.U	**Description of Process:** Northeast Health Partners follows Beacon's Member Rights and Responsibilities Policy and Non-Discrimination Policy to comply with other federal and State laws that pertain to Member rights. See 310LNonDiscriminationPolicy_2RAE, page 1 and 304LMemberRandRPolicy_2RAE, page 5. Right violations are monitored through the complaint process. Rights violations is one of the complaint categories in our complaint reporting system and we are able to pull a report of complaints related to member rights and take action if any is warranted. If a Member believes that their rights have been violated, they can make a complaint at any time by phone, letter, in person, or an email. Beacon's Member Engagement Specialist will listen to the Members complaint about their rights being violated and will investigate the complaint and follow up with a Complaint Resolution Letter. Beacon tracks all complaints, including complaints about any rights being violated in our Feedback Database (see Feedback Database_NHP. (See Feedback Database_NHP).	
6. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224*	**Documents Submitted/Location Within Documents:** 1. 33.4_UsesandDisclosureofPHI policy_2RAE, entire policy *misc. 2. 304L_MemberRandRPolicy_2RAE pages 2-3, 8-9, 3. PCMPFullAccountableAgreement_2RAE, page 10 *misc. 4. HIPAAPrivacy_NHP, page 1 *misc. 5. HIPAASecurity_NHP, entire document *misc. 6. HIPAA_NHP, entire document *misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: 20.A Exhibit A—2.c and 3.a	**Description of Process:** NHP 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). NHP follows Beacon's Policy 33.4 Uses and Disclosures of PHI which is the overall policy on disclosures in accordance with privacy rules. On page one (1) the policy states that we may use and disclose PHI only as permitted or required by federal privacy law and relevant state law. This would include 45 CFR parts 160 and 164. NHP follows 304L MemberRandRPolicy which states on page 8 that the confidentiality policies and procedures must conform to all federal and state confidentiality laws and regulations (See G. i.) In this same policy, it states that Members have the right to request and obtain a copy of their PHI and ask NHP to amend or correct their PHI (see pages 8, g/iv/2 and3). On page 2 of this same policy, it states that members will be furnished with health care services in accordance with requirements for timely access and medically necessary coordinated care (see xiii). The entirety of the RAE Compliance Plan contains written policies, procedures and standards of conduct which articulate the RAE's commitment and ability to comply with all applicable contract, federal and State requirements. NHP requires Primary Care Medical Providers who are accountable providers to sign an agreement. (See PCMPFullAccountableAgreement_2RAE). On page 10 (10) the	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agreement states that the PCMP is and remains responsible for compliance with all applicable provisions of state and federal law, which includes a Member's medical record. NHP follows the following policies: • HIPAA Privacy states on page one (1) that NHP will ensure the privacy of an individual's health and personal information as requirement by federal and state regulations. • HIPAA Security outlines how NHP will protect Members' PHI; • HIPAA_NHP outlines that NHP will designate a Privacy Office to ensure Member's privacy.	
7. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. • The difference between institution wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection.	**Documents Submitted/Location Within Documents*:*** 1. 269L_AdvanceDirectivesPolicy_2RAE, entire policy 2. AdvanceDirectivesPolicyLegalReivew_2RAE, entire document 3. MemberLetter_NHP, entire document 4. TownHall_NHP, page 12 *misc. 5. TownHallSigninSheets_NHP, entire document *misc. **Description of Process:** NHP has a written policy and procedure relating to Advance Directives. A copy of this policy is located on our website under Advance Directives/Living Will. Click on Advance Directives Policy. We have also attached 269L_AdvanceDirectivesPolicy_2RAE to review the policy in its entirety demonstrate that we have a policy in place for all adult individuals receiving care through the RAE.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives.	NHP sends an annual mailing to Members directing them to the website to find out about Advance Directives. Members, Providers and Stakeholders can access NHP's website, Advance Directives/Living Will, and have access to links for Colorado Medical Advance Directives, Five Wishes, and Achieve Solutions articles on Advance Directives. There is information about what constitutes an Advance Directive with an emphasis that an Advance Directive is designed to enhance an incapacitated individual's control over medical treatment. We have provided a link to Colorado's website with applicable State Law on Advance Directives. The RAE collaborates with providers at town hall meetings to identify how providers work with Members regarding Advance Directives. See TownHall_NHP and TownHall SigninSheets_NHP.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives. • Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.1.3–7		

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

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

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit B1—7.3.6.1	**Documents Submitted/Location Within Documents:** 1. Wellpass_NHP, entire document 2. WebsiteScavangerHunt_NHP,entire document *mics. 3. CareCoordinationMinutes0718_NHP, Pages 2 and 4 4. CareCoordinationMinutes1018_NHP, Page 3 **Description of Process:** NHP launched a texting campaign in January 2019 designed to help Members understand the requirements and benefits of their health plan. The name of the texting campaign is called Wellpass. There are several topics which are texted to Members to help them learn about their benefits. These include: Member Handbook and Website Link; Well Child Visits, Nurse Help Line, Member Rights, Coverage, Community Resources; Primary Care, Adult Annual Physicals, Suicide, Advance Directives, Vaccinations, Mental Health, ER Avoidance, Insurance Card, Member Information, and Care Management. Please see Wellpass_NHP for the specific text scripts. The Member Services Department developed a Website Scavenger Hunt (see Website Scavenger Hunt_NHP) for topics that Members are encouraged to look up to learn about their benefits. The Member Services team distributes these fliers at the following meetings: Program Improvement Advisory Council, Member Experience Advisory Council, and Ice Cream and Information events. NHP recognizes that Care Coordinators are crucial in helping Members navigate and understand their benefits. During the monthly Care Coordination meetings, the Member Services Director provides updates on benefits and highlights events which Members can be	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	involved in to better understand their benefits. Please see CareCoordination Minutes 0718_NHP and Care Coordination Minutes 1018_NHP for examples.	
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.	**Documents Submitted/Location Within Documents:** 1. ManagedCareTerminology_2RAE, entire document 2. HealthFirstColorado_StyleGuide_2RAE, page 7 **Description of Process:** NHP understands the need for consistency in the information that is provided to our Members between the state and our RAE. NHP has researched managed care definitions provided by Healthcare, Policy, and Financing in the Health First Colorado's (Colorado's Medicaid Program) Member Handbook and developed a Managed Care Terminology resource for our members which is located on our website see Managed Care Terminology. It is located under the Resource tab/Managed Care Terminology. When you click on the Managed Care Terminology icon, Members can access a PDF Document with the definitions for the terms (see ManagedCareTerminology_2RAE). NHP uses the Member Handbook developed by the State of Colorado, Department of Healthcare, Policy, and Financing (HCPF). This is displayed on the main page of our website, Northeast Health Partners. NHP models member notices after Health First Colorado's style guide. On page six (6) of the style guide, we have highlighted the specific instructions on how to message Members. Please see the	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(c)(4) Contract Amendment 1: Exhibit B1—3.6, 7.3.4	same messaging which is listed on our website. See What is a Regional Organization?	
Findings: The Department has not provided a list of these definitions to the RAEs, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the RAE to be aware of this requirement and to consistently use definitions from the Department when available.		
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency.	**Documents Submitted/Location Within Documents:** 1. DefinitionofPrevalentNonEnglishSpeakers_2RAE, page 8 2. NonEnglishSpeakingSummary_NHP, entire document 3. ProviderDirectory_NHP, page 1 4. AppealReceiptLetter_NHP, page 1 5. ComplaintReceiptLetter_NHP, page 1 6. ComplaintGuide_NHP, page 1 7. AppealGuide_NHP, page 1 8. State Fair Hearing Guide_NHP, page 1 9. NoticeofAdverseBenefitDeterminationLetter_NHP, page 1 10. ProviderTerm_NHP, entire document 11. AppealDecisionLetter_NHP, page 1 12. ComplaintResolutionLetter_NHP page 1 13. 307L_MemberInfoReqPolicy_2RAE, page 1and 2 *misc. 14. 311L_HandlingCallsWithLimitedEnglishSpeakingMembersPolicy_2RAE-entire policy 15. MeetingMinutes_NHP, page 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Include taglines in large print (18-point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit B1—7.2.7.3–9; 7.3.13.3	**Description of Process:** NHP researched the prevalent non-English language spoken in our region. According to Rule #MSB 17-01-18-A in the Revision to the Medical Assistance Rule Concerning Managed care, "prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the state. According to Data USA, there are 13.58% of Non-English Speaking members in Region 2. In 2015, the most common non-English language spoken in Colorado was Spanish. 10.5% of Colorado's overall population are native Spanish speakers, followed by German at .45% and Chinese at .41%. Based on this information, the most prevalent non-English language in Colorado is Spanish. NHP has over one-hundred (100) languages accessible through Google Translate available on our website Northeast Health Partners). In the upper right hand corner of the website, you can click on the flag to access other languages. NHP has uploaded a copy of Health First Colorado Member Handbook Spanish on the main page of our website. Members can access this handbook on our main page by clicking on the handbook icon. (See Spanish Member Handbook. NHP has taglines in large print and prevalent non-English language which describes how a Member can request auxiliary aids and services, written translation, or oral interpretation. We include our toll free and TTY/TDY customer service number on our website. See Northeast Health Partners website in the upper right hand corner. NHP explains the availability of materials in alternative formats at no charge to the member. See Member Tab. We have included several examples of materials that are critical for Members to obtain services including provider directories, appeal, complaint, notice of adverse	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	benefit determination, and letters to Member of provider terminating. See Appeal Receipt Letter_NHP, Complaint Receipt Ack Letter_NHP, Notice of Adverse Benefit Determination Letter_NHP, Letter to Member of Provider Terminating_NHP, Appeal Decision Letter_NHP, Complaint Resolution Letter_NHP, Complaint Guide_NHP, Appeal Guide_NHP, and State Fair Hearing Guide_NHP. NHP follows the Member Material policy (307L Member Info Req Policy_2RAE) to ensure that Member materials are accurate, easily understood, culturally relevant, clear, available in other languages at no charge to the member and available in alternative formats. NHP runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. See 307LMemberInfoReqPolicy_2RAE page 2 for readability testing guidelines. NHP follows policy (311L Handing Calls for Limited English Speaking Members_2RAE) which guides our calls with limited English speaking members. We utilize Voiance® translation line which allows us to expediently connect Members with an interpreter in over 150 languages. The Member Services Subcommittee reviews Member materials and requests that Advocates review Member materials with Members. See MeetingMinutes_NHP, page 3.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	**Documents Submitted/Location Within Documents:** 1. IT302.3_508ComplianceofExternalWebSitesPolicy_2RAE-entire policy 2. WebsiteComplianceCheck_NHP - entire document 3. WebsiteUpdateRequests_2RAE, entire document 4. 307L_MemberInfoReqPolicy_2RAE, page 3 *misc. 5. WebsiteUpdateRequests_2RAE, December 2018 Tab **Description of Process:** NHP does make information available to our Members electronically on our website, Northeast Health Partners. NHP has delegated the execution of website content and monitoring to Beacon Health Options. Beacon has a policy to guide the requirements of being readily accessible. See IT302.2 508 Compliance of External Websites_2RAE. Beacon regularly runs 508/WCAG scans for their websites to resolve accessibility issues they can control (they cannot control PDF content). Beacon runs all PDF documents through an accessibility scan before uploading the content to the website. The 508/WCAG reports are shared monthly so that everyone is aware of what needs to be resolved and so that accessible PDFs and content can be provided to remediate the issues. See Website Compliance Check_NHP. Beacon National corrects the majority of these accessibility issues. NHP reviews content on a monthly basis to update relevant information for our Members. See WebsiteUpdateRequests_2RAE. We inform Members that they can request any information at no charge upon request and that will provide this information to them within five working days. Please see Member Tab for this information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	To demonstrate that that our information can be electronically retained and printed, we have attached Provider Directory_NHP which was printed from the website. NHP has a Member Material policy (307L Member Info Req Policy_2RAE) which we follow to ensure that Member materials are accurate, easily understood, culturally relevant, clear, available in other languages at no charge to the member and available in alternative formats. NHP runs member materials through a Flesch-Kinkaid Score which is obtained through Microsoft Word. See 307LMemberInfoReqPolicy_2RAE page 2 for readability testing guidelines.	
6. The RAE makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: Exhibit B1—None	NHP has information about Member's prescription formulary available on our website. See Resources under Prescription Information. Magellan's RX Management website is listed on the Magellan RX's website. We inform Members that anything on our website can be sent to them in paper form. See Member Tab for evidence.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The RAE makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.	**Documents Submitted/Location Within Documents:** 1. AppealReceiptLetter_NHP, page 1 2. ComplaintReceiptLetter_NHP, page 1 3. Notice of Adverse Benefit Determination Letter_NHP, page 1 4. 311L_HandlingCallswithLimitedEnglishSpeakingMembers_2RAE – entire document 5. EvidenceofInterpretationServices_2RAE, entire document 6. 307L_MemberInfoReqPolicy_2RAE, entire document *misc. 7. ProviderHandbook_2RAE, page 17 *misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The RAE notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and informs how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit B1—7.2.6.2–4	**Description of Process:** NHP makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and how Members can access them. This includes the use of auxiliary aids such as TTY/TDY and American Sign Language. This information is embedded in the taglines for all of NHP's correspondence which we send Members. See Appeal Receipt Letter_NHP, Complaint Receipt Letter_NHP, and Notice of Adverse Benefit Determination Letter_NHP for a few examples. NHP's phone numbers are in a prominent place on our website and in our Member brochures. Please see Northeast Health Partners website in the upper left hand corner. We inform Members that they have these services available to them at no charge on our website. Please see Member Tab. NHP follows the policy 311L Handling Calls with Limited English Speaking Members_2RAE to ensure that members have access to oral interpretation for any language free of charge. This policy is provided as evidence for compliance with this standard because most requests for oral interpretation or written translation of Member materials are made telephonically. We have a guide attached to the policy, "Working with Interpreters," which guides staff members on how to use an interpreter. NHP does provide brief education about using interpreters prior to the interpreter appointment. Beacon Health Options contracts with Voiance® to provide interpreter services for our members in over 150 languages. Voiance	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	is a leading provider of language interpreting services and their services are available 24/7. This service is used for members calling into our Access to Care Line, or members who request an oral interpretation of written materials into a language other than English or Spanish. This service allows us to provide interpreter services in "real time." Page 2 of the policy 311L Handling Calls with Limited English Speaking Members_2RAE outlines how to use Voiance. See EvidenceofInterpretationServices_2RAE. NHP uses Relay Colorado for members who are deaf or hard of hearing. If interpreter services will be needed for clinical services, NHP will find a provider in the network who is proficient in sign language, or contract with a sign language interpreter if no providers are available in the region. Policy 311L Handling Calls with Limited English Speaking Members_2RAE outlines how to use Relay Colorado on page 2 and 3. The policy outlines on page three the process for when a provider and or PIAC/MEAC chair needs an interpreter for a meeting. Providers are made aware of their responsibility to offer interpreter services for Member in the Provider Handbook_2RAE on page 17. It also explains that providers can contact NHP to receive help with this. NHP also provides a link for free sign language interpreting services, RISP, for rural counties. All nineteen (19) counties are eligible for this program. Please see the Resource Tab. NHP follows the policy, 307L_Member Info Req Policy_2RAE. The policy outlines on page 3 that Member materials are orally translated	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	into other languages by request at no charge to the member. The policy states that Member Materials are available in alternative formats for Members who have communication disabilities free of charge. Alternative formats include large type, audio tape, TTY/TDY, and American Sign Language.	
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit B1—7.2.6.1, 7.2.6.5	**Documents Submitted/Location Within Documents:** 1. 311L_HandlingCallswithLimitedEnglishSpeakingMembers_2RAE, pages 1,2 and 5-6 2. ProviderHandbook_2RAE, page 17 *misc. 3. ComplaintGuide_NHP, page 2 4. AppealGuide_NHP, page 2 **Description of Process:** NHP ensures that language assistance is provided at all points of contact for a Member, in a timely manner, and during all hours of operation. NHP's customer service telephone number ensures easy 24/7 hour access for interpreter or bi-lingual services. NHP follows the policy 311L Handling Calls with Limited English Speaking Members_2RAE. On page 1, it states that language translation services are available 24/7, 365 days a year. On page 2, the process for how to use the translation line is outlined. On pages 5-6, there is a guide attached to the policy, "Working with Interpreters" which directs staff members on how to use an interpreter. NHP does provide brief education about using interpreters prior to the interpreter appointment. Beacon Health Options contracts with Voiance® to provide interpreter services for our members in over 150 languages. Voiance	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	is a leading provider of language interpreting services and their services are available 24/7. See their website by clicking on VOIANCE. This service is used for members who call our Customer Service number. This service allows us to provide interpreter services in "real time." See Evidence of Using Interpretation Services_2RAE. If a Member requests an oral interpretation of written materials into a language other than English or Spanish, we utilize Voiance to meet this need. NHP may use Voiance® initially to determine the extent of the need for further interpreter services when a Member needs to facilitate communication between two parties. If we ascertain that interpreter services will be needed beyond the initial call, the request is forwarded to the Member Engagement Specialist who will request interpretation services. On page 3 of 311L Handling Calls with Limited English Speaking Members_2RAE, it outlines this process. If interpretation services are needed for an administrative reason (complaints or appeals) the Member Engagement Specialist will connect with the interpreter and set an appointment(s) to discuss the complaint or appeal. See page 2 of ComplaintGuide_NHP, page 2 of AppealGuide_NHP. These guides are in English and Spanish on our website. See Complaints and Appeals. When a Member requires language interpretation for clinical services, a Provider can contact NHP. The Member Engagement Specialist will assist in the provider and will connect them with Asian Pacific Center. Asian Pacific Center has interpreters available for face-to-	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	face, telephonic, or Skype interpretation in approximately seventy (70) languages. You can visit their website Asian Pacific Center. Providers can find out about this in the provider handbook on page 17. See Provider Handbook_2RAE. NHP uses RelayColorado for members who are Deaf or hard of hearing. If interpreter services will be needed for clinical services, the Member Engagement Specialist will find a provider in the network who is proficient in sign language, or contract with a sign language interpreter if no providers are available in the region.	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit B1—None	**Documents Submitted/Location Within Documents:** 1. Wellpass_NHP, entire document **Description of Process:** NHP has delegated Beacon Health Options to run monthly reports of members who are new to NHP. These members will be sent a text which states, "Want a copy of your member handbook? Need to find a doctor? Visit www.northeasthealthpartners.org to check out all of the information and tools we offer. A copy of the member handbook is available on the main page of our website. See Northeast Health Partners. See Wellpass_NHP for content for text messaging.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: NHP does not produce a RAE-specific member handbook.		

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

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Providers may end up this report for several reasons such as: 1) Providers who have not returned re-credentialing paperwork; 2) Providers who have not re-validated with the State; 3) Providers who have not filed a change of address; 4) Providers who have not met other administrative requirements; 5) Providers who have had a serious violation; or 6) Providers who have informed Beacon that they are voluntarily withdrawing from the Network. This report can be up to 90 days before a provider officially gets dis-enrolled. This time frame allows providers time to fulfill administrative requirements or to appeal a pending disenrollment decision. When a provider has exhausted all appeals, we receive a final report which contains Members who will need to have their care transitioned to a new provider. This is approximately 45 days before final disenrollment. However, there are times a provider moves, resigns from the network, or leaves the network in some other way. Provider Relations expediently informs Member Services when a provider is voluntarily dis-enrolling from the network. Member Services sends the Member a letter (see ProviderTerm_NHP) to any Member who had been seeing the dis-enrolled provider during the previous six months. A letter is sent within 15 days of dis-enrollment when possible. Situations where we would not inform members within the 15-day window would be when the provider informs us after they have closed their practice, or upon the death of a provider. In these cases, we inform members as soon as possible after we receive the information.	

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	updates. Included in this process is ensuring our PDF documents are 508 compliant. For evidence of information that we have uploaded to the site, see WebsiteUpdateRequests_2RAE.	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated*	**Documents Submitted/Location Within Documents:** EvidenceofProviderDirectoryUploadedMonthly_2RAE, page 2 MonthlyUploadDirectory_2RAE, entire document ProviderDirectory_NHP, entire document **Description of Process:** NHP has delegated provider oversight to Beacon Health Options. Beacon's Provider Relations Department ensures the provider directory is available to our members in paper or electronic means. The Provider Directory is a list of contracted primary care providers, behavioral health providers, and hospitals. Providers/Facilities street address, telephone number, website address, linguistic capabilities (including American Sign Language), specialties, cultural competency training, if new patients are being accepted and ADA compliance. Members are able to obtain a copy of our contracted providers on our website and print off a copy. See Find A Provider. When a Member clicks on this tab, they have options to view the provider directory or use other links to find a PCP, dentist, specialist, or pharmacist. Members can also use Referral Connect to find a behavioral health provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
no later than 30 calendar days after the contractor receives updated provider information. *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit B1—7.3.9.1.6	Members can contact our toll free number and request a copy of the Provider directory. Members can also search in Referral Connect and search providers by specialist, American Sign Language, handicapped accessible, near public transportation, and providers accepting new patients. Many Members choose to call into the call center to request Health First Colorado providers in their vicinity. A Clinical Service Assistant (CSA) will use our Referral Connect system to find providers near the Member. A CSA can search several fields including specialties, language, gender preference, and access for disabilities. If a Member has a certain request for specialized equipment for their disability, a Member Services team member would reach out to the PCP to see if they can accommodate the Member's request. Providers can update their information on Provider Connect. Updated information can be phone numbers, addresses, specialties, whether they are currently accepting new patients, or linguistic capabilities, or access for physical disabilities. Providers notify Beacon when they are unable to accept new Members. Provider Relations staff will list their practice as full and remove these providers from the next provider directory upload. Provider Relations has not received an example of request under the RAE to share. Beacon will use Providers' information to update the Provider Directory, including any of these changes on a monthly basis	

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	refer to Priority 1 Checklist (items which must be addressed and are required to make a site accessible) on pages 2-3. Beacon runs 508/WCAG website scans monthly to resolve accessibility issues. The 508/WCAG reports is reviewed by a Beacon staff member to resolve and remediate any issues. See Website Compliance Check_NHP. Beacon runs Adobe Acrobat Pro on the provider directory on a monthly basis prior to posting the directory on the website.	
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • RAE's single toll-free customer service phone number. • RAE's email address. • RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit.	**Documents Submitted/Location Within Documents:** 1. Brochure_NHP, entire document *misc. 2. InformationOneStop_NHP, entire document *misc. 3. ComplaintReceiptLetter_NHP, entire document 4. Wellpass_NHP, entire document **Description of Process:** NHP has developed electronic and written materials for distribution for newly enrolled and existing members. The name of the website is: www.northeasthealthpartners.org. For evidence of written materials, please see Brochure_NHP. NHP's single toll free customer service phone number and state relay number are listed in both the brochure and in the upper left hand corner of the website and under Contact Tab. The email address is listed under the Contact Tab and on the inside of the brochure. NHP also developed flyers with the website address to be placed at provider's offices, shelters, libraries, mental health centers, etc. See InformationOneStop_NHP. NHP also sends Members texts with NHP's phone number and website address. See Wellpass_NHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The RAE will annually mail each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit B1—7.3.8.1	**Documents Submitted/Location Within Documents:** 1. AppealReceiptLetter_NHP, page 2 2. ComplaintReceiptLetter_NHP, page 2 3. MemberLetter_NHP, entire document 4. Member Mailing Price Quote_2RAE, entire document. **Description of Process:** NHP will annually mail each member a notice that instructs them how to request a copy of the handbook. NHP has contacted Webb Mason for this mailing. See Member Mailing Price Quote_2RAE. For a copy of the mailing, please see MemberLetter_NHP. NHP also has revised all of their member mailings to include in the footer how Members can obtain a copy of the Member handbook. See AppealReceiptLetter_NHP and ComplaintReceiptLetter_NHP for a few examples.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Effective March 20, 2019, the Department informed HSAG and each RAE that this requirement will be deleted from the RAE contract: therefore, HSAG scored this element *Not Applicable*.		
18. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in	**Documents Submitted/Location Within Documents:** 1. MemberLetter_NHP, entire document 2. InformationOneStop_NHP, entire document *misc. 3. Wellpass_NHP, entire document 4. IceCreamandInfo_NHP, entire document *misc. 5. EvidenceofPermissiontoEmail_NHP Pg. 1, 2 **Description of Process:** NHP provides member information through a variety of means. The predominant method is through our website, Northeast Health	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit B1—None	Partners. NHP sends an annual letter to member directing Members to the website to find out information about the Member Handbook, benefits, rights, and Advance Directives. There are taglines on every letter stating that NHP will provide auxiliary aids and services upon request at no charge. NHP posts information on our website and informs members that they can access this information by going to the site through a mailing. See Member Handbook Mailing_NHP, Information One Stop_NHP, and Wellpass_NHP to demonstrate how Members are directed to the website. Wellpass is our texting campaign that provides Members with information about their plans and benefits. For an example of the texting campaigns, please see Wellpass_NHP. NHP will provide information through Email when we have the Member's consent to receive information by email. Please see Evidence of Permission to Email_NHP. NHP also provides Member information through the method of Information and Ice Cream. See flyer IceCreamandInfo_NHP. Beacon's Member Services team goes into the community to host trainings on Member Rights, Responsibilities, or How Members Can Use Their Benefits. Members are encouraged to ask questions about their benefits during these luncheons. The Member Services team educates Members on the availability of our website and distributes NHP's brochures. In the most recent event, put on their evaluation	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	form that one of the most helpful things about the presentation was the information on the website.	
19. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit B1—None	NHP does not have any physician incentive plans currently in place.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: NHP staff members reported that the RAE has no physician incentive plans as such plans are defined in the RAE contract with the State.		

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

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. Contract Amendment 1: Exhibit B1—7.3.12.1	**Documents Submitted/Location Within Documents** 1. RAE website: https://www.northeasthealthpartners.org/ 2. NOABD_NHP, page 1 3. Brochure_NHP - entire document *misc. 4. IceCreamandInfo_NHP - entire document *misc. 5. WebsiteScavangerHunt_NHP - entire document *misc. 6. InformationOneStop_NHP - entire document *misc. 7. MEACminutes_NHP- entire document 8. EPSDTTrainingSignInSheet_2RAE - entire document **Description of Process:** NHP uses a variety of mechanisms to communicate with its members about the EPSDT program and how to access services. Members are informed about the EPSDT program through the Health First Colorado Member Handbook which is located on the front page of our website: https://www.northeasthealthpartners.org. The website also has information about the EPSDT benefit under MEMBER TAB/Benefits and Services (see website). It is listed at the very top "*What are Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefits?*" If services have been denied to an eligible Member, the Notice of Adverse Benefit Determination letter (see NOABD_NHP) informs Members/Parents/Guardians of the potential to use EPSDT benefits to cover denied services or other recommended services that may not be covered under the capitated behavioral health benefit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members can find out about the website through a variety of platforms. The website address is listed at the bottom of all of our correspondence, on our brochures, and through posters displayed at multiple sites. We developed an Information One Stop poster to alert potential Members of the website. See InformationOneStop_NHP. This poster has been discussed at both Program Improvement Advisory Council and Member Experience Advisory Council meetings. Members brainstormed the following places to hang the posters including: community mental health centers, laundromats, post offices, Salvation Army, soup kitchens, bus stations, libraries, churches, and medical clinics (see MEACminutes_NHP). NHP uses lunch-and-learn forums with Members to discuss benefits, rights, and responsibilities. During an "Ice Cream and Information" meeting for NHP Members, we reviewed Members' rights and educated Members on the website and passed out the website scavenger hunt. (See IceCreamandInfo_NHP) The scavenger hunt has a section for Members to locate the EPSDT benefits on the website. See WebsiteScavengerHunt_NHP. NHP held a training on both EPSDT benefits and Health Communities with Gina Robinson and Jeff Helm to educate Call Center staff, Care Coordinators, and Providers on EPSDT benefits and how to connect with a Family Health Coordinator [See EPSDTTrainingSignInSheet_2RAE; held on 9/5/18]. Information on how to find a Family Health Coordinator in your area can be found on our website (https://www.northeasthealthpartners.org) under COMMUNITY TAB/Healthy Communities. Call Center staff have	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	been trained to link EPSDT eligible Members to Healthy Communities.	
2. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information: • The RAE employs Department materials to inform network providers about the benefits of well-child care and EPSDT. • The RAE ensures that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 1: Exhibit B1—7.6.2.3, 12.8.3.4; 12.9.3.4	**Documents Submitted/Location Within Documents** 1. 248L_EPSDT policy_2RAE, entire policy 2. BH_Procedures_2RAE, Slide 32 to 35 3. ProviderHandbook_2RAE, Pg. 20, 30, 40-42*misc. 4. TownHall_NHP, page 10 *misc. 5. TownHallSigninSheets_NHP, entire document *misc. **Description of Process:** The RAE's contracted behavioral health providers are responsible for documenting the results of all screenings, assessments and examinations for members receiving behavioral health services. This requirement is stated in policy 248L_EPSDT_2RAE-Entire Policy, specifically in section IV. J: "The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered." Providers are instructed about this requirement in training about Behavioral Health Procedures, which includes specific information about EPSDT. For latest version, see BH_Procedures_2RAE—Slide 32 to 35. This training is made available to providers when they	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	enroll in the provider network and is always available in the provider section of the RAE's website. The BHO's Provider Manual also contains information about the EPSDT program and its documentation requirements. Please see highlighted areas on pp. 20, 30, and 40-42 of the ProviderHandbook_2RAE. The RAE educates providers regarding EPSDT benefits at Town Hall meetings. See TownHall_NHP and TownHallSigninSheets_NHP.	
3. The RAE shall create an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE shall train Healthy Communities contractors about the Accountable Care Collaborative and the RAE's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	**Documents Submitted/Location Within Documents** 1. HealthyCommunitiesPresentation_NHP- entire document 2. HealthyCommunities_RAE_MOU_NHP- entire document **Description of Process:** The RAE has developed a presentation slide deck to train Healthy Communities contractors about the Accountable Care program and the specific responsibilities and functions of the RAE. This presentation has been or will be delivered to each of the Healthy Communities offices in the covered region. See **HealthyCommunitiesPresentation_NHP.** The RAE has developed MOUs with each Healthy Communities program office in its area. These memoranda provide detail about the expectations of each organization with respect to training, referrals, and identification of resources. A sample/template of this MOU is provided as evidence. See **HealthyCommunities_RAE_MOU_NHP**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	NHP has collaborated with all ten (10) Healthy Communities counties in region 2 and has developed Business Associates Agreements (BAA) and a Memorandum of Understanding (MOU) with these agencies. The primary purpose of the BAAs and the MOU is to ensure that duplication in services are reduced and that there is a clear line between onboarding Members under twenty-one (21) and pregnant mothers. These Members are directed to Healthy Communities for engagement and Members over twenty-one (21) are directed to NHP for onboarding/member engagement. A secondary purpose of BAAs and the MOU is to strengthen the community partnerships to enhance Members' engagement in their own healthcare. The Care Coordinators have regular meetings with Healthy Communities to discuss referral processes, referrals, collaboration, prenatal care, and identifying local resources. The Care Coordinators and Family Health Coordinators collaborate on a daily basis to ensure that Members are engaged in the care they need.	
4. The RAE assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit B1—12.8.7.6	**Documents Submitted/Location Within Documents** 1. HCPF list of family health coordinators by county: https://www.colorado.gov/pacific/hcpf/family-health-coordinator-list or FAMILY_HEALTH_COORD_LIST_2RAE- entire document 2. HCPF EPSDT website: https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt or HCPF_EPSDT_WEBSITE_2RAE - entire document 3. HCPF PAR website: http://coloradopar.com/ or CO_PAR_WEBSITE_2RAE- entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: In addition to training providers about EPSDT requirements during their onboarding process, the RAE provides ongoing support, subject matter expertise, and resources to help providers resolve any barriers related to the EPSDT program. The RAE can provide a list of the Healthy Communities programs that serve a particular area. The RAE's call center and provider relations staff also are available to answer questions about the EPSDT benefit. When necessary, RAE staff can help link providers to HCPF's EPSDT and Prior Authorization Request (PAR) websites. The RAE also can link providers to the State EPSDT Program Manager, Gina Robinson. When appropriate, the RAE can work with providers to request a Creative Solutions meeting that will bring together members, families, providers, RAE representatives, the State EPSDT Program Manager, DHS, and other stakeholders.	
5. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280. (EPSDT program). For the Capitated Behavioral Health Benefit, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental	**Documents Submitted/Location Within Documents** 1. 248L_EPSDT policy_2RAE-Entire Policy 2. ProviderHandbook_2RAE_PG 20, 30, 40-42*misc. 3. BH_Procedures_2RAE—Slide 32 to 35 **Description of Process:** The RAE has a written policy related to the EPSDT program and its requirements. See **248L_EPSDT policy_2RAE** in its entirety. This policy defines eligibility for the EPSDT program as follows [Section II.A]: Any person enrolled in the Health First Colorado (Medicaid) program can get EPSDT services if they are 20 years old or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
screening to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	younger. They are automatically enrolled and all Health First Colorado providers can offer the EPSDT services. 1. Children 18 years old and younger can get EPSDT with no co-pay for any covered service. 2. Adults 19 and 20 years old can get EPSDT, but may have a small co-pay for some services. 3. Children in Department of Social and Human Services custody can get ESPDT services with no co-pay, if they are 18 or younger. They may have some co-pays if they are 19 or 20. 4. EPSDT services may include, but not be limited to the following: providing EPSDT program information to members and families, screening (assessment), diagnosis, treatment, discretionary services (e.g., medically necessary wraparound services), referral and care coordination, and transportation and scheduling assistance. The RAE ensures that EPSDT screenings (assessments) are provided by primary care physicians, pediatricians, or other qualified providers whenever requested and according to the recommended periodicity schedule [**248L EPSDT policy, Sections II.B and II.C**]. Members are informed of this right and providers are informed of their responsibilities through the RAE's website and through various training resources. The RAE's EPSDT policy specifically outlines the procedures for obtaining the results of EPSDT screenings and documenting the results [**248L EPSDT policy, Section IV, A-P**]. The RAE's contracted behavioral health providers are responsible for documenting the results of all screenings, assessments and examinations for members receiving behavioral health services. This	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requirement is stated in **248L EPSDT policy, specifically in section IV.J**: "The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered." Providers are instructed about this requirement in their onboarding training, which includes specific information about **EPSDT. See BH_Procedures_2RAE—Slide 32 to 35**. The BHO's Provider Manual also contains information about the EPSDT program and its documentation requirements. Please see **ProviderHandbook_2RAE, PG20, 30, 40-42**.	
6. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start;	**Documents Submitted/Location Within Documents** 1. ProviderHandbook_2RAE,PG 20, 30, 40-42*misc. 2. 248L_EPSDT policy_2BHO-Entire Policy [Section IV.O]. **Description of Process:** The RAE's **ProviderHandbook_2RAE_PG 20, 30, 40-42** and EPSDT policy give additional clarification about offering the family or beneficiary assistance with referral assistance, appointment scheduling or transportation services [**248L EPSDT policy_2RAE, Section II.A, last bullet point**]. The RAE has allied with community and governmental agencies such as Community Centered Boards, Single Entry Point agencies, maternal and child health programs, Head Start, WIC, SNAP, vocational rehabilitation, and other organizations providing medically	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61-62* Contract Amendment 1: Exhibit B1—14.5.3	necessary services that are not covered under the capitated behavioral health benefit [**248L_2RAE, Section IV.O**]. Members can obtain referrals to these programs by contacting the RAE's Access to Care line. The RAE and its behavioral health providers refer children and their families to the local Healthy Communities program for additional assistance regarding transportation issues, appointment assistance, and administrative case management. Information about the Healthy Communities program is also available on the RAE's website.	
7. *For the Capitated Behavioral Health Benefit,* the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the	**Documents Submitted/Location Within Documents** 1. 248L_EPSDT policy_2RAE, entire policy **Description of Process:** The RAE has defined medical necessity for EPSDT services in its EPSDT policy, **248L_EPSDT_2RAE**. Please see Section II. D (pp. 3-4) for this medical necessity definition, and see Sections IV.M through IV.O (pp. 6-7) for the UM processes related to the authorization of covered versus non-covered medically necessary services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
8. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities; clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 1: Exhibit B1—14.5.8.1	**Documents Submitted/Location Within Documents** 1. Technical Proposal_NHP, pp. 254-261. 2. NHP_ 1915b3 Waiver Services Grid, entire document **Description of Process:** NHP and its network of providers are fully capable of delivering all of the mandatory services identified in this requirement. See **Technical Proposal_NHP (pp. 254-261)** for a description of these services and the **NHP_ 1915b3 Waiver Services Grid** for a list of locations and hours of service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard XI—EPSDT Services							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	100%

Appendix B. Record Review Tools

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

Appendix C. Site Review Participants

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

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Kathy Bartilotta	Associate Director
NHP Participants	**Title**
Anne Fritz	Supervisor, Care Management
Brandy Brown	Performance Improvement Coordinator
Deb Barnett	Director, Quality Improvement
Erica Arnold-Miller	Vice President, Quality Management
Jennifer Hale-Coulson	Director, Care Coordination (Beacon)
Joanna Martinson	Director, Care Coordination (NCHA)
Kara Doone	Data Analyst
Kari Snelson	Executive Director
Katie Tann	Supervisor, Care Management
Lisa Clements	Vice President, Population Health
Liz Hickman	Centennial Mental Health Center—Board Member
Lynne Bakalyan	Director, Member Services
Mandi Strickland	Business Development
Meredith Munoz	Community Action Collaborative Coordinator
Nicholas Batchelor	Community Healthcare Manager
Rachel Artz-Steinberg	Assistant Director, Care Coordination
Rachel King	Manager, Care Management Program
Steve Coen	Director, Utilization Management
Victoria Lopez	Care Manager
Wayne Watkins	Director, Information Technology
Department Observers	**Title**
Kayla Tuteur	Program Specialist—HCPF
Natasha Brockhaus	Program Administrator—HCPF
Russell Kennedy	Quality Compliance Specialist—HCPF
Gina Robinson	EPSDT Program Administrator

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

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

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

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
9. *For the Capitated Behavioral Health Benefit*: The RAE ensures that each provider furnishing Services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	NHP demonstrated having adequate policies, monitoring tools, and communications to providers regarding requirements for maintaining member health records in compliance with detailed documentation standards and for maintaining confidentiality and security of member health records. In addition, care compacts between individual referring and specialist providers—totaling 69 signed agreements at the time of on-site review—required sharing of clinical information between those specific providers. However, no other NHP documents clearly communicated expectations that all providers *share* member records with other providers or organizations involved with a member's care.	NHP must enhance provider communications regarding the requirement that each provider furnishing services to the member *share*, as appropriate, the member health record with other providers or organizations involved in the member's care.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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

Overview of FY 2018–2019 Focus Topic Discussion

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

Members

Transitioning Members Into the RAE and Continuity of Care

Prior to implementation of the RAE contact, Colorado Access held the contract for both the behavioral health organization (BHO) and the Reginal Collaborative Care Organization (RCCO) in Region 2. **NHP**'s shareholders include the two CMHCs—previously affiliated with Colorado Access' BHO—and two FQHCs—previously affiliated with Colorado Access' RCCO. **NHP**'s organizational model incorporates Beacon Health Options (Beacon) as the administrative services organization (ASO), which was not engaged in Region 2 prior to implementation of the RAE. In addition, North Colorado Health Alliance (NCHA)—previously associated with Colorado Access' RCCO was retained as a delegated care coordination entity in **NHP**. Whereas Beacon had no pre-existing sources of information—e.g., UM records or daily inpatient census reports—to identify members involved in active BH treatment at the time of transition to the RAE, **NHP** worked with Colorado Access to identify members engaged in services or at risk of needing BH services. **NHP** reported a number of issues in working with Colorado Access to smoothly transition members engaged in higher levels of care, including that members engaged in higher levels of care were not identified to **NHP** until day of discharge and that **NHP** was unable to interpret Colorado Access' list of high-risk members. **NHP** therefore began working with its partner CMHCs who could identify through crisis intervention programs or case manager discharge planners many of the members engaged in services or who were at-risk members. **NHP** also worked with the Department's Creative Solutions coordinator to identify members engaged in high-level BH services. In addition, NCHA's integrated care coordination program—providing care coordination services for 80 percent of members in the region— could identify members engaged in BH services. **NHP** targeted communications to the providers for these members to communicate that the previous BHO remained responsible for costs of previously authorized inpatient services through member discharge and informed providers of continued authorization processes through Beacon. Likewise,

payment for high-level, previously authorized outpatient services remained the responsibility of the BHO until the July 1, 2018, implementation of the RAE, at which time continuing services for members were authorized through Beacon. Beacon implemented after-hours capacity for processing authorization requests. Staff members reported that 75 percent of **NHP** BH members received ongoing mental health services through the two partner CMHCs and two large counseling centers in the region and targeted those providers for early contracting with the RAE. By working with providers behind the scenes, members continued care with their current providers and transition to the RAE was essentially transparent to members.

To identify members at risk of needing BH care, **NHP** met with all county Departments of Human Services in the region to identify members needing BH care and worked with NCHA to identify members stratified as high-risk for BH needs. Care coordinators (CCs) and CMHCs outreached to these members to: explain transition from the BHO to the RAE; ensure members that BH benefits would not change; and offer care coordination services, if indicated.

Prior to initiation of the RAE, **NHP** invested in mass communication efforts with members through mailers, town forums, and dissemination of information through its shareholder CMHC and FQHCs and the Frontier House drop-in center. **NHP** used this opportunity to reach out to BH members to inform them of the new health plan name, answer questions, and ensure members that benefits and services would not change. Beacon conducted extensive training of call center staff to ensure staff members' abilities to answer member inquiries regarding the transition to the RAE. Staff members communicated the belief that early efforts by **NHP** to communicate with members regarding transition were effective in alleviating member anxieties regarding RAE implementation and reported that while members were confused, they did not complain.

NHP anticipated a higher probability of problems for members due to the new PCMP-based attribution methodology. Staff members stated that checking the Department's portal for RAE attribution was initially confusing. **NHP** worked with the Office of Behavioral Health to identify members originally assigned to the BHO in Region 2 and likely receiving BH services in Region 2, but attributed to a PCMP in another region. **NHP** also encouraged providers to closely monitor their Medicaid patient listings in comparison to attribution lists and to identify inconsistencies. **NHP** identified that many attribution concerns were associated with the following select populations: members residing in Region 2 who were seeking care from PCMPs in neighboring Larimer County, particularly with one PCMP that bordered both Weld and Larimer counties; children in the custody of DHS child welfare in Region 2 counties but who were in foster care placement with families in other areas of the State; members who lived in other areas of the State but worked in Region 2 counties, where they would most likely select a provider close to work; aging members or nursing home residents in LTSS services—i.e., LTSS certifications communicated with each member's assigned PCMP; and special needs members receiving services through Children's Hospital providers attributed to Region 3 rather than to PCMPs in Region 2. **NHP** worked with the Department on macro-level attribution issues, primarily related to the geographic assignment methodology; and CCs contacted individual members to assist with reattribution. **NHP** reported that attribution issues had improved since inception of the RAE; nevertheless, Region 2 experienced an overall reduction of 10,000 to 12,000 members in the transition from RCCO to RAE attribution methodology.

Care Coordination

In addition to the various methods of identifying high-risk members for care coordination described previously, **NHP** CCs communicated with a variety of sources—including school -based BH practitioners in 26 locations within the region and county Women, Infants, and Children (WIC) programs—to identify members receiving BH services or who were high-risk members. NCHA's relationship with the numerous community agencies and provider entities belonging to the alliance enabled identification of high-risk populations involved in community-based targeted intervention programs. CCs then outreached to these populations to ensure continuity of services and engage members in care coordination when needed. CCs also contacted and worked with members who appeared mis-attributed to introduce the RAE and offer care coordination services. When a member engaged in authorized services or care coordination was attributed to another RAE, the CC or UM staff contacted RAE care coordinators in other regions to alert them to the member and to transfer member-specific information. Staff members stated that care coordinators carried a heavy workload during the initial period of transition to the RAE. Due to NCHA's pre-established care coordination relationship with providers and members attributed to Region 1—significantly to the PCMP practices bordering Weld and Larimer counties—NCHA care coordinators have continued to coordinate care for members with complex needs attributed to Region 1 but living in Region 2, in order to maintain continuity of services with providers in Region 2. During on-site interviews, staff members also described a unique pilot program, initiated by **NHP** and Craig Hospital in Denver, to collaboratively coordinate services for spinal cord and brain injury patients between Craig Hospital and the RAEs.

NCHA has embedded BH care coordinators in several large PCMP practices and maintains a diversity of care coordinator expertise within its integrated care coordination teams. Centennial Mental Health has embedded BH practitioners in Salud clinics. Upon RAE implementation, **NHP** worked with care coordination teams to define the roles of BH and physical health (PH) CCs in the collaborative care coordination teams.

Providers

Transitioning BH Providers Into the RAE and Provider Network Contracting

In order to facilitate BH provider contracting with the RAE, **NHP** initially used Colorado Access' BHO list of contracted providers, **NHP**'s partner CMHCs, and NCHA's community agency partners to identify and target providers for contracting with the RAE. Staff reported that initial contracting efforts focused on the CMHCs and two large counseling centers, which collectively provide BH services to 75 percent of BH members in the region. Independent practice network (IPN) providers, who require support from the CMHCs for member care, maintain close working relationships with regional CMHCs. Staff reported that all previously contracted BHO providers transitioned their contracts to the RAE. Beacon has also contracted with an additional 200 IPN providers in combined Region 2 and Region 4 and reported that 24 of those providers were still in the credentialing process at the time of on-site

review. DHSs provided Beacon a list of providers that they desired for contracting with the RAE. Region 2 also has 26 school-based BH providers and specialized BH services and programs in rural areas of the region. Beacon continues to recruit BH providers, including providers for higher levels of care, to expand capacity within the rural areas of the region, where BH services are limited. Most providers targeted for recruiting are identified through word-of-mouth referrals.

NHP conducted early education of IPN providers regarding integration of BH providers into the RAE, new authorization processes, monitoring requirements, and other administrative changes. Staff members stated that IPN providers had been relatively isolated from the ACC program as well as from the previous RCCO and were dismayed with changes in the Medicaid program. The requirement for all BH providers to contract with multiple RAEs has been an administrative burden for IPN providers.

NHP also held weekly webinars with PCMPs to provide updates from the State regarding the "silent" RAE contracting process, explain the new per member per month (PMPM) reimbursement, and prepare PCMPs for attribution issues. Staff members stated that PCMPs were initially "shocked" by the changing PMPM and attribution methodology. **NHP** ensured providers that they could continue to serve and be paid for care of members despite mis-attribution and encouraged providers to monitor their practice attribution lists and work with **NHP** and care coordinators to resolve attribution issues. **NHP** also conducted a "cultural change" webinar session to help PCMPs understand communications with BH providers integrated into the RAE. While members experienced a relatively seamless transition upon implementation of the RAE, providers had to absorb the impact of infrastructure issues—e.g., billing and payment structures, authorizations, communications among providers, new ACC rules and expectations—associated with the new integrated RAE model and new **NHP** RAE contractor. In addition, **NHP** staff stated that PCMPs and BH providers do not understand each other's processes in the integrated delivery system model and that extensive provider education is still needed. **NHP** plans to work through provider consortiums such as Thriving Weld, to engage an increased number of providers in RAE provider education and trainings and will conduct all future town hall webinars to simultaneously include both PH and BH providers.

CMHCs have embedded BH providers in all FQHCs for provision of co-located BH and PH services as follows: North Range BH practitioners are embedded in Sunrise and some area Salud clinics; Centennial BH practitioners are embedded in Peak Vista and the Fort Morgan and Sterling Salud clinics. In addition, a PH provider is embedded at North Range Behavioral Health. In these co-located BH/PH practices, the Department's reimbursement of six FFS BH codes has had no apparent impact on integrated care for members. However, staff members articulated several issues related to reimbursement of six limited BH codes in other PCMP practices, including that billing for six routine behavioral health visits is an administrative burden for providers, who are not using those codes for Medicaid members; members who must be transitioned from the six initial PCMP sessions to a behavioral health provider—i.e., CMHC—must adjust to a totally different therapeutic environment and may be vulnerable to gaps in services when transitioned; and, the ability for PCMPs to provide six sessions of BH services has stimulated only two PCMPs to initiate provision of office-based BH therapies. **NHP** concluded that the "six-BH-session" benefit has not expanded service to members and has potentially been harmful to the provision of effective integrated care for members.

Due to the vast distances, limited services, and sparse population in Region 2's rural areas, **NHP** is supportive of implementing telehealth services wherever possible to enhance the delivery of care. Staff described that Region 2 experiences a general workforce shortage in the rural areas, a shortage of BH providers available for recruitment to the RAE network, and lack of substance abuse disorder (SUD) providers throughout the region. Several telehealth initiatives are already underway in the region: Centennial Mental Health and Heart-Centered Counseling provide telepsychiatry; Banner provides telehealth to its partner providers; HealthONE provides telehealth to some areas of the region; and Children's Hospital provides clinic services to members through county public health departments and has identified funding to implement telehealth to expand services to routine primary care providers. Despite these programs, only 38 percent of Region 2 providers are aware of telehealth services, and staff stated that provision of in-home telehealth services is not anticipated any time in the near future due to lack of an adequate Internet infrastructure in some rural areas. Staff members believed that schools and hospitals provide better access points for telehealth. Lincoln County Hospital is building the infrastructure for telehealth services.

Opportunities/Challenges

Despite the limited availability of traditional provider resources throughout the Region, **NHP** believes that Region 2 has many resources available to members through the broader health neighborhood. The region has a unique history of building alliances of healthcare providers, agencies, and community organizations so as to meet the needs of populations in local communities throughout the region. **NHP** credits the Weld County North Colorado Health Alliance and long-term leadership of its chief executive officer (CEO) for building relationships of organizations and developing programs to serve members throughout the region. These pre-established alliances enable **NHP** to "come alongside" and be a participant in collaborative efforts to improve healthcare for RAE members. **NHP** considers innovative and community-based initiatives of the health neighborhood to be essential for reforming healthcare and providing services to members in rurally-oriented RAE regions and perceives the need for improved financial margins in the RAE to sustain initiatives of the health neighborhood.

PCMPs throughout the region have pre-established relationships with specialists, primarily through Banner Health (Banner) in Weld County. Following RAE contract implementation, **NHP** encountered unusually divisive political dynamics between the hospital systems in Weld and Larimer counties, which resulted in Banner attempting to withdraw from Medicaid. Such a move threatened to disrupt established referral patterns among PCMPs and specialists within the region. **NHP** required the assistance from Department leadership to strongly recommend to Banner that this issue be resolved. Also related to referral relationships with specialists, PCMPs and specialists have been reluctant to engage in formal care compacts with providers with whom they have longstanding working relationships.

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

NHP is concerned about the future fatigue of care coordination and case management staff who have carried much of the burden during implementation of the RAE. In addition to the time-consuming and emotionally draining commitment to meeting Medicaid members' multiple needs, care coordinators assume a major workload in a system that does not recognize the complexity of such efforts through existing reimbursement or payment mechanisms. Furthermore, NCHA has maintained care coordination responsibilities for members who reside in and receive most of their services from providers in Region 2 while some members have been attributed to the Region 1 RAE, which is receiving payment for those care coordination services.

NHP is concerned about the consistency in direct and indirect messaging from the Department, which appears to place emphasis on cost-savings rather than on improving member-focused care and services. Whereas the RAEs and providers have been historically member-oriented and invested in health reform for Colorado Medicaid members, the Department now appears to be focused on measuring "widgets" of RAE processes, and increasingly portrays cost savings as the paramount objective of the ACC. As previously stated, many of the successes in Region 2 are attributed to innovative, community-based efforts of the health neighborhood. To that end, **NHP** suggests that the Department reassess its measurement and payment strategies—e.g., PMPM, key performance indicators (KPIs), and other anticipated "value" payments—to reflect the overall mission of the ACC and in-depth expectations of the RAE contract, recognizing the varying cultures and resources in each region. Mechanisms to improve the RAEs' overall financial margins may ultimately be essential for sustaining the flexibility to implement region-specific objectives.

Despite confusing policy-level directives from the Department, **NHP** believes that the collaborative partnerships between the Department and the RAE, as well as among the RAEs, have been maintained or enhanced to overcome the challenges of transitioning to the new RAE model. **NHP** observed that stabilization of staff in both the Department and RAEs will further improve collaborative endeavors.