



COLORADO

**Department of Health Care
Policy & Financing**

Fiscal Year 2019–2020 Site Review Report
for
Northeast Health Partners
Region 2

May 2020

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



Table of Contents

1. Executive Summary	1-1
Introduction	1-1
Summary of Compliance Results	1-2
Standard I—Coverage and Authorization of Services	1-3
Summary of Strengths and Findings as Evidence of Compliance	1-3
Summary of Findings Resulting in Opportunities for Improvement	1-4
Summary of Required Actions	1-4
Standard II—Access and Availability	1-4
Summary of Strengths and Findings as Evidence of Compliance	1-4
Summary of Findings Resulting in Opportunities for Improvement	1-5
Summary of Required Actions	1-5
Standard VI—Grievances and Appeals	1-6
Summary of Strengths and Findings as Evidence of Compliance	1-6
Summary of Findings Resulting in Opportunities for Improvement	1-6
Summary of Required Actions	1-8
2. Overview and Background	2-1
Overview of FY 2019–2020 Compliance Monitoring Activities	2-1
Compliance Monitoring Site Review Methodology	2-1
Objective of the Site Review	2-2
3. Follow-Up on Prior Year’s Corrective Action Plan	3-1
FY 2018–2019 Corrective Action Methodology	3-1
Summary of FY 2018–2019 Required Actions	3-1
Summary of Corrective Action/Document Review	3-1
Summary of Continued Required Actions	3-1
Appendix A. Compliance Monitoring Tool	A-1
Appendix B. Record Review Tools	B-1
Appendix C. Site Review Participants	C-1
Appendix D. Corrective Action Plan Template for FY 2019–2020	D-1
Appendix E. Compliance Monitoring Review Protocol Activities	E-1
Appendix F. Focus Topic Discussion	F-1

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 primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCM entities and PIHPs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. 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) 2019–2020 site review activities for **Northeast Health Partners (NHP)**. For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals 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 2019–2020 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 FY 2019–2020 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)
I. Coverage and Authorization of Services	34	30	29	1	0	4	97%
II. Access and Availability	16	16	15	1	0	0	94%
VI. Grievances and Appeals	35	35	27	8	0	0	77%
Totals	85	81	71	10	0	4	88%

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

Table 1-2 presents the scores for **NHP** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	60	53	7	30	88%
Grievances	60	49	48	1	11	98%
Appeals	36	35	28	7	1	80%
Totals	186	144	129	15	42	90%

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

NHP submitted a large body of evidence to substantiate compliance with coverage and authorization of services requirements. **NHP** delegated utilization management (UM) functions for all behavioral health service to Beacon Health Options (Beacon). **NHP**'s submission included policies, procedures, reports, work plans, tools, manuals, and sample denial and extension letters. HSAG reviewed all submissions and found that the documents illustrated a thorough and comprehensive approach for review, authorization, and denial of RAE-covered services.

During the on-site denial record reviews, HSAG observed that the notice of adverse benefit determination (NOABD) demonstrated the required content, including the reason for the decision, the member's right to appeal and to request a State review, and the possibility of requesting continued service/benefits pending the resolution of the appeal. Authorization requests could be submitted by phone, fax, or through **NHP**'s "Connect" system. Regardless of the method of submission, all authorization requests were documented in the Connect system—**NHP**'s proprietary integrated data and information system. **NHP** staff members demonstrated the Connect system during the on-site audit, and HSAG observed documentation of all required processes related to initial and continuing authorization of services. On-site denial record reviews demonstrated that **NHP** expediently processed all authorization requests.

NHP's *Medically Necessary Determinations, Lack of Information Timelines* policy outlined the required time frames for making standard and expedited authorization decisions and information required to do so. **NHP**'s sample denial records were standard authorization requests that illustrated compliance with decisions being made within 10 calendar days following the receipt of the request for service. HSAG observed time stamps on the requests and decisions completed.

NHP explained that requests for authorization can be approved at different levels based on staff credentials. **NHP** staff members apply InterQual criteria to medical records and clinical criteria. **NHP**'s clinical care managers (CCMs) are typically licensed Master's level professional counselors or certified social workers. CCMs can authorize services within a predetermined scope of care—e.g., outpatient care, acute treatment units, partial hospitalization program, and some inpatient services. All requests for services outside of the CCM's scope of authorization—intensive outpatient treatment services, residential treatment, retroactive authorizations, single case agreements, and/or complex mental health conditions (e.g., eating disorders)—must be reviewed by one of **NHP**'s medical directors with specialization in Psychiatry. CCMs do not have the authority to deny any request for authorization; all adverse benefit determinations are reviewed and denied at the medical director level. **NHP**'s staff members described the close working relationships and open communication with its contracted providers, facilities, community mental health centers (CMHCs), and community stakeholders. **NHP** credits these strong relationships with the RAE's ability to obtain the clinical information necessary to render a timely decision (i.e., less than 10 days) and identify community resources to ensure smooth member transitions to a lower level of care.

Summary of Findings Resulting in Opportunities for Improvement

Regarding authorization requests processed during business hours, **NHP** referred HSAG to the notes in the Connect system that documented the “time of receipt” of an authorization request and “time of decision.” Due to the possibility that entering staff notes in the system may not always be real-time, HSAG cautions that consistent documentation of time stamps would be necessary to ensure compliance with time frames applicable to expedited authorization requests. HSAG recommends that **NHP** implement a process to use the time stamp in the Connect system to accurately document receipt of requests and decisions made on authorization requests.

Summary of Required Actions

NHP demonstrated that the NOABD included all required content and was available in prevalent non-English languages and alternative formats for persons with special needs. However, HSAG found seven of 10 denial record reviews were *Not Met* for “correspondence with the member was easy to understand.” **NHP**’s reason for the adverse benefit determination incorporated language such as “exclusionary criteria,” “lower level of care,” “less intensive,” and “less restrictive” in describing the reason for the denial, which would be difficult for Medicaid members with limited reading ability to understand. **NHP** must ensure that the NOABD in its entirety is written in language that is easy for a member to understand.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

NHP delegated the functions of maintaining, evaluating, and monitoring the provider network to Beacon. **NHP**’s document submission included policies, procedures, GeoAccess reporting, work plans, committee meeting minutes, provider education/training, provider directory, and sample provider single case agreement letters. HSAG reviewed all submissions and found that documents demonstrated compliance with access and availability requirements.

NHP’s *Provision of Service Through an Out of Network Provider* policy illustrated the process and procedures for implementation and use of single case agreements (SCAs). Since opening the RAE network to all providers interested in contracting, the instances of SCAs have decreased. Staff members reported that most SCAs apply to providers that are engaged in the process of credentialing. The SCA allows for no disruptions in the continuity of care while the contracting process is being finalized. SCAs are also used for providers that can offer care in a specific language or render care/treatment of a specific condition such as eating disorders. **NHP** generated a monthly internal report to monitor SCAs issued by the RAE. **NHP** used the report to identify opportunities to pursue and establish new provider network contracts. The RAE also compared the attribution report received from the State to its existing provider network to identify providers that are not contracted. The RAE described actions taken by the Provider

Relations Department to initiate contracting discussions with these providers. **NHP** submitted its provider manual, Access to Care Standards Training Webinar, and BH Access to Care webpage to demonstrate its efforts to educate the provider network on the required appointment standards for timely access to care.

During on-site interviews, **NHP** described its efforts to promote the delivery of services in a culturally competent manner. The RAE's rural and frontier geographic service areas include many different cultures that **NHP** takes into consideration when anticipating and meeting the healthcare needs of its members. **NHP**'s community care coordinators engage members in their homes, support them at behavioral and physical health appointments, and partner with community stakeholders. **NHP** described two unique scenarios that exemplify its ability to identify member needs and enhance delivery of services in a culturally sensitive manner:

- **NHP** provided an outreach and education initiative specific to the unique needs and challenges that impact the mental health of the farming, migrant worker, and agricultural communities within the region. Due to concerns regarding the increase in the number of suicides among this population, the RAE partnered with its CMHC in the area to develop a multi-dimensional initiative that included educating the community about the importance of mental health; ensuring that providers were trained and qualified to offer support and guidance to address the stress experienced by community members; and making resources, materials, and hotlines available to the community. The RAE and CMHC leveraged the support of farming supply companies and other community businesses to distribute education and messaging regarding available resources. **NHP** also deployed mobile health vehicles to provide care to farmers and migrant workers.
- **NHP** described an instance in which a Somali member's newborn had been transferred from their rural area to the neonatal intensive care unit at an urban hospital. Once **NHP** was made aware of the newborn's hospitalization and the mother's lack of interpretation services, a care coordinator was physically dispatched to the hospital to serve as a translator and support for the mother.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

NHP implemented a phone survey of a small sample of the behavioral health network providers to evaluate the availability and timeliness of scheduling appointments for RAE members. The December 2019 survey results illustrated that all of the standards were met by only one of the seven providers surveyed. **NHP** must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). **NHP** must also ensure implementation of corrective action plans for providers that are not in compliance with the access to care standards.

Standard VI—Grievances and Appeals

Summary of Strengths and Findings as Evidence of Compliance

NHP delegates processing of appeals and grievances to its partner organization, Beacon. Beacon delegates processing of grievances applicable to its own members to two CMHCs. The *Complaint Delegation and Procedures* agreement thoroughly outlined grievance procedures and expectations of the delegates with oversight by Beacon. In addition, staff members stated that Salud Family Health Centers, Sunrise Community Health, and Frontier House (North Range Behavioral Health) staff members were trained to assist members in filing a complaint with **NHP**. Beacon maintained comprehensive grievance and appeal policies and procedures and member template communication documents addressing all grievance and appeal requirements, including: accurate definitions of “adverse benefit determination,” “appeal,” and “grievance”; accepting verbal or written grievances and appeals; maintaining a designated client representative (DCR) process; provision of assistance to members in preparing grievances and appeals; consideration of all information submitted by the member or DCR when processing grievances or appeals; accurate time frames for providing notices to members with required content; and ensuring appropriate reviewers for making decisions on grievances and appeals. During on-site interviews, staff members demonstrated thorough understanding of all grievance and appeal requirements. On-site grievance record reviews demonstrated 98 percent compliance overall with all applicable requirements. On-site appeal record reviews demonstrated 80 percent compliance overall, which included 100 percent compliance in three of the six appeal requirements. Beacon maintained local medical reviewers and a panel of corporate peer advisors with clinical expertise to make denial and appeal decisions, enabling decisions to be made by appropriate reviewers and to be made within all required time frames. Beacon time- and date-stamped all appeal requests and notices of resolution to enable expedited decisions to be made with 72 hours. Member notices of grievance and appeal resolution were written in easy-to-understand language, including taglines and offering alternative formats for members with special needs. Notices to members included all required information. Beacon maintained a grievance database for tracking grievance processes that collected all required information from both delegates and **NHP** staff members concerning grievances throughout the region. Beacon maintained an appeal database meeting all appeal data requirements and enabling reporting to the Department. The **NHP** provider handbook thoroughly outlined the member grievance and appeal processes.

Summary of Findings Resulting in Opportunities for Improvement

The information in the appeal resolution letter related to continuing benefits during a State fair hearing (SFH) did not clarify that the member must be the one to request continued benefits (i.e., not the provider) and did not explain that a request for continued benefits during an SFH applies only if the member had also continued benefits during the appeal. HSAG recommends that **NHP** enhance its appeal resolution letter to address these clarifications.

HSAG noted that the provider handbook did not indicate *how* a member must request continued benefits (e.g., from **NHP**) nor did it specify that a provider cannot request continued benefits on behalf of a member. HSAG recommends that **NHP** consider adding these clarifications to the provider handbook.

During on-site appeal record reviews, eight of 15 records were omitted from the sample as “appeals not processed” due to provider procedural issues—e.g., appeal filed outside required time frame and/or no member DCR form. HSAG noted that claims not paid (and related appeals) due to reasons of procedural issues on the provider’s part are not member appeals and should be processed through **NHP**’s provider dispute process. To that end, HSAG strongly recommends that **NHP** enhance internal procedures to:

- Ensure provider appeals of unpaid claims (if due to provider procedural issues) are not recorded in the member appeal database and are internally redirected to staff members responsible for processing provider disputes. Members should not be informed of provider procedural or payment issues, as these are not member appeals and do not concern the member.
- Ensure **NHP** informs the requesting provider that provider payment appeals received through the member appeal process are not member appeals and the provider may alternatively use the provider dispute process.
- Ensure that **NHP** does not inadvertently deny a provider his or her right to consideration through the provider dispute process.
- Enhance provider training and communications to emphasize that the provider dispute process is the mechanism through which provider procedural issues and payment disputes may be considered.

HSAG noted that, when an appeal is requested by the member’s DCR, the appeal resolution letter is directed to the DCR—often a provider—and copied to the member. Whereas regulations require notice to the member, **NHP** may want to consider directing the letter to the member and copying the DCR/provider. In addition, HSAG observed that the appeal resolution letter includes language explaining “What this means to the provider” followed by “What this means to the member.” Since this is a member appeal, the member does not need to be concerned with what this means to the provider. The letter also includes extensive information on how the appeal decision was made. HSAG recommends that **NHP** consider simplifying the content of the appeal resolution letter to more overtly state the appeal decision and, if the appeal decision upholds the original denial, consistently communicate that the member cannot be billed by the provider for unpaid services.

The **NHP** provider handbook described a peer-to-peer reconsideration process “after denial of authorization.” During on-site interviews, staff members clarified that the NOABD is pending for 24 hours to allow for the peer-to-peer reconsideration. HSAG cautions that **NHP** ensure the peer-to-peer reconsideration is consistently applied prior to issuing the NOABD; otherwise, this process constitutes a second level of appeal.

Complaint Delegation and Procedures requires that delegated entities enter grievance information in the **NHP** grievance (“feedback”) database within one week following the end of each month. Staff members explained that **NHP** monitors the appropriate processing of grievances through the feedback database. HSAG encourages **NHP** to consider requiring delegates to more frequently enter documentation of

grievances in the grievance database to enable more timely monitoring of delegates' grievance processing and trends.

Summary of Required Actions

NHP's template complaint resolution letter was written in language easy for the member to understand. However, HSAG found during grievance record reviews that one resolution letter processed by a delegated entity used language such as "reiterated" and "regional organization," which would not be easily understood by a member with limited reading ability. **NHP** must develop a mechanism to ensure that each grievance resolution letter is written in language easy for a Medicaid member to understand.

While **NHP's** *Appeal Policy*, related procedures, and *Appeal Guide* for members, all required resolution of complaints within 10 working days, HSAG found during on-site appeal record reviews that one case was *Not Met* for resolution of a standard appeal within the required time frame. In addition, HSAG found that one appeal resolution letter included clinical acronyms regarding alternative therapies (e.g., "MST") that would not be easy for the member to understand. **NHP** must ensure that:

- All standard appeal decisions are made within 10 working days from receipt of the appeal, unless the decision time frame is extended.
- Information in the appeal resolution letter does not include clinical information that would be difficult for a member to understand.

NHP's appeal policy and related procedures described resolution of expedited appeal decisions with 72 hours of receipt. However, during on-site appeal record reviews, HSAG found one expedited appeal in which the member was promptly notified verbally of the decision but **NHP** failed to send the written resolution to the member within the 72-hour time frame. **NHP** must develop a mechanism to ensure that written notice to the member of an expedited appeal decision is sent within 72 hours of receipt of the appeal request.

While internal policies and procedures accurately defined the content of the appeal resolution letter, the content of actual appeal resolution letters and the *SFH Guide* insert included several inaccuracies related to procedures and circumstances for requesting continued benefits during an SFH. As further described in the findings of Standard VI, elements # 26 and #29 in the Compliance Monitoring Tool incorporated in this report, inaccuracies included:

- Neither the appeal resolution letter nor the *SFH Guide* explained *how* the member may request continued benefits during an SFH—i.e., through **NHP** within 10 days of receiving an adverse appeal resolution notice.
- The *SFH Guide* stated that the criteria for continuing benefits during an SFH included "the time period for the authorized services must not yet be over" (applies to continued benefits during appeals but not SFH).
- The *SFH Guide* stated that the criteria for continuing benefits during an SFH included "the member must request an SFH within 10 days."

- The *SFH Guide* included the description, “you do not request an SFH and continued services within 10 days of an appeal decision not in your favor” as a criterion for how long benefits will continue during an SFH (applies to continued benefits during appeals but not an SFH).

NHP must revise its appeal resolution letter and *SFH Guide* to accurately describe the procedures and circumstances for requesting continued benefits during an SFH.

NHP’s provider handbook included inaccuracies in the circumstances and standards related to requesting continued benefits during an SFH (as described above). **NHP** must revise the grievance and appeal information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH.

The sample *Overtured Appeal Decision* letter inappropriately informed the member that he or she may request an SFH. A request for an SFH applies only to “appeals not resolved in favor of the member.” **NHP** must also remove information regarding the member’s right to request an SFH from its *Overtured Appeal Decision* letters.

The *SFH Guide* inaccurately stated, “If **NHP** does not follow the appeal time frames, you may request an SFH *before you file an appeal*.” The member must file an appeal with **NHP** before requesting an SFH. **NHP** must correct its *SFH Guide* to remove the phrase “before you file an appeal” from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames.

During appeal record reviews, HSAG found the appeal resolution letter included information pertaining to continued benefits during the SFH in cases where continuing benefits were not applicable in the individual member’s situation. Therefore, four of six eligible appeal record reviews were *Not Met* for “resolution letter includes required content.” **NHP** must ensure that information pertaining to continuation of benefits during an SFH is not included in letters where continuation of benefits does not apply to the member’s situation.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three 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 2019–2020 was *Region-specific Initiatives Related to the Health Neighborhood*.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three 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*. The Department determined that the review period was January 1, 2019, through December 31, 2019. 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 each of denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to RAE denials of authorization, grievances, and appeals to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial records, all grievance records, and all appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

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*. 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 three standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

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 three 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: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **NHP** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed 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 (EPSDT) Services.

Related to coordination and continuity of care, **NHP** was required to enhance provider communications to require that each provider furnishing services to the member shares, as appropriate, the member health record with other providers or organizations involved in the member's care.

Summary of Corrective Action/Document Review

NHP submitted a proposed CAP in June 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **NHP**. **NHP** submitted initial documents as evidence of completion in October 2019. Following review by HSAG and the Department, **NHP** was required to resubmit additional documentation as evidence of completion in December 2019. HSAG and the Department found the required action was successfully completed in March 2019.

Summary of Continued Required Actions

NHP successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.</p> <p><i>42 CFR 438.210(a)(3)(i)</i></p> <p>Contract: Exhibit B-2—14.6.2</p>	<p>Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted.</p> <p>Evidence:</p> <ol style="list-style-type: none">1. NHP Management Services Agreement, pages 14-162. 202L--Medical Necessity Determinations, section 11. C3. Health First Colorado Member Handbook, pages 18-24 *Misc. <p>Narrative:</p> <p>All utilization management (UM) functions for the capitated behavioral health benefit of Northeast Health Partners' Medicaid contract are delegated to Beacon Health Options as the administrative services organization for NHP (see NHP Management Services Agreement). As UM functions are delegated to Beacon, its policies and procedures showcase NHPs' adherence to State and Federal requirements for the coverage and authorization of services; thus, Beacon's policies and procedures are referenced throughout this compliance monitoring tool.</p> <p>The amount, duration, and scope of services is limited only by the determination of medical necessity (see Section II.C of 202L--Medical Necessity Determinations). Services that are determined to be medically necessary are not otherwise limited. For example, there are no episode</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	of care, annual, or lifetime benefit limits. Services under this health plan are not less than the amount, duration, and scope of services that are available under fee-for-service Medicaid. A description of the covered services can be found in the Health First Colorado Member Handbook as well (see pages 18-24).	
<p>2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.</p> <p style="text-align: right;"><i>42 CFR 438.210(a)(3)(ii)</i></p> <p>Contract: Exhibit B-2—14.6.4</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 202L--Medical Necessity Determinations, section II, D Exhibit I-Capitated BH Benefit Covered Services and Diagnoses, entire document 303L--Peer Advisor Adverse Determinations, entire policy Level of Care-Medical Necessity Guidelines folder <p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon's UM staff refer to the medical necessity policy (see 202L--Medical Necessity Determinations, section II, D), the list of covered diagnoses (see Exhibit I-Covered Behavioral Health Services and Diagnoses), and the clinical level of care criteria (see Level of Care-Medical Necessity Guidelines folder) to authorize care to help ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Care can be denied by only the</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Medical Director or the Clinical Peer Advisor (see 303L--Peer Advisor Adverse Determinations, entire policy).</p> <p>Variables such as the member's situation and other care available are considered in each individual situation. UM staff work with providers to review the member's care and give input into discharge planning to help members achieve long-term stabilization and sustained improvement. Beacon's UM staff refer cases for possible adverse clinical decisions to the Medical Director/Peer Advisor for review (see 303L--Peer Advisor Adverse Determinations, entire policy).</p>	
<p>3. The Contractor may place appropriate limits on services—</p> <ul style="list-style-type: none"> On the basis of criteria applied under the Medicaid State plan (such as medical necessity). For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. <p style="text-align: right;"><i>42 CFR 438.210(a)(4)</i></p> <p>Contract: Exhibit B-2—14.6.5, 14.6.5.1–2</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 202L--Medical Necessity Determinations, section 1, Section II.E Exhibit I-Capitated BH Benefit Covered Services and Diagnoses, entire document Level of Care-Medical Necessity Guidelines folder <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. The Medical Necessity Determinations policy incorporates the elements of the State's definition for medical necessity and notes that Beacon can make medical necessity determinations for the purpose of utilization control (see Section I. and Section II.E in 202L--Medical Necessity Determinations). The list of covered diagnoses is stipulated by NHPs' Medicaid contract (see</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	Exhibit I-Covered Behavioral Health Services and Diagnoses). The level of Care guidelines are the basis for any limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals (see Level of Care-Medical Necessity Guidelines folder). Each level of care guideline contains evidence informed inclusion and exclusion criteria designed to authorize care for the members who would reasonably be expected to benefit from the service. Criteria are outlined to continue authorization for members who are progressing in treatment or who need to have treatment plans adjusted by providers to address any lack of progress. Care managers actively work with providers during reviews, based on the LOC criteria to shape treatment so that it will achieve the care needs of members.	
<p>4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor).</p> <p style="text-align: right;"><i>HB19-1269: Section 3–10-16-104(3)(B)</i></p> <p>Contract: Exhibit B-2—14.6.5.2.1</p>	<p>Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's.</p> <p>(No desk review documentation from health plan needs to be submitted)</p> <p>Evidence:</p> <ol style="list-style-type: none"> 1. NHP Management Services Agreement, pages 14-16 2. 202L--Medical Necessity Determinations, entire policy, especially Section II.F 	<i>For Information Only</i>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. See NHP Management Services Agreement, pages 14-16. The RAE is committed to ensuring access to and coverage of services that are in parity with all medical/surgical benefits in the same classification furnished to members.</p> <p>The amount, duration and scope of covered behavioral health services is limited by only the determination of medical necessity (see Section II.F of 202L Medical Necessity Determinations). Beacon may place limits on services for utilization control, as agreed to by NHP, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members.</p> <p>Services that are determined to be medically necessary are not otherwise limited. For example, there are no financial, episode of care, annual, or lifetime benefit limits. Services under this health plan are not less than the amount, duration, and scope of services that are available under fee-for-service Medicaid.</p>	



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service.</p> <p><i>HB19-1269: Section 12—25.5-5-402(3)(h)</i></p>	<p>Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's.</p> <p>(No desk review documentation from health plan needs to be submitted)</p> <p>Evidence:</p> <ol style="list-style-type: none">202L--Medical Necessity Determinations, Section II.G.Exhibit H Developmental Disability and Traumatic Brain Injury Guidance, entire policy <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. According to Beacon's policy titled "202L--Medical Necessity Determinations" (see Section II.G.), the presence of a co-morbid intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service. It is noted that such conditions often co-occur with behavioral health disorders. This can present challenges for providers who are trying to assess and treat an individual's covered behavioral health needs.</p> <p>A guidance document for the evaluation and treatment of intellectual or developmental disabilities (see Exhibit H Developmental Disability and Traumatic Brain Injury</p>	<p><i>For Information Only</i></p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Guidance) was developed by the previous Behavioral Health Organizations in collaboration with the Community Centered Boards, developmental disability professionals, member advocates, and other key stakeholders, in the interest of fulfilling their responsibilities under the Colorado Medicaid Program. This guidance document was adopted by the BHOs, and it was subsequently adopted by the RAEs as part of the ACC program.</p> <p>A similar document was developed for the evaluation and treatment of individuals with a covered mental illness and a co-morbid Traumatic Brain Injury. This guidance document was adopted by the RAE as part of the ACC program contract (See Exhibit H and Section II.G. of 202L--Medical Necessity Determinations).</p>	
<p>6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions.</p> <p><i>HB19-1269: Section 12—25.5-5-402(3)(i)</i></p>	<p>Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's.</p> <p>(No desk review documentation from health plan needs to be submitted)</p> <p>Evidence:</p> <ol style="list-style-type: none">202L--Medical Necessity Determinations, Section II.H.Exhibit I-Capitated BH Benefit Covered Services and Diagnoses, entire document <p>Narrative:</p>	<p><i>For Information Only</i></p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	This required element is delegated to Beacon Health Options by NHP. According to Beacon’s policy titled “202L--Medical Necessity Determinations”, all medically necessary covered treatments for covered behavioral health diagnoses are covered, regardless of any co-occurring conditions (see Section II.H. of 202L--Medical Necessity Determinations). The list of covered services and diagnoses is provided in Exhibit I-Capitated BH Benefit Covered Services and Diagnoses.	
<p>7. The RAE defines medical necessity for services as a program, good, or service that:</p> <ul style="list-style-type: none">• Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.• Is provided in accordance with generally accepted professional standards for health care in the United States.• Is clinically appropriate in terms of type, frequency, extent, site, and duration.• Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.• Is delivered in the most appropriate setting(s) required by the client’s condition.• Is not experimental or investigational.• Is not more costly than other equally effective treatment options. <p>42 CFR 438.210(a)(5)</p>	<p>Evidence:</p> <p>1. 202L--Medical Necessity Determinations, Section II.A.</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Medically necessary services are needed for the diagnosis or treatment of health impairments and also to prevent deterioration in functioning as a result of a covered mental health disorder (see Section II.A. of 202L--Medical Necessity Determinations).</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
Contract: Exhibit B-2—2.1.62 10 CCR 2505-10 8.076.1.8		
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. Contract: Exhibit B-2—14.8.2 <i>42 CFR 438.210(b)(1)</i>	<p>Evidence:</p> <ol style="list-style-type: none">204L--Intake Data Collection Initial Auth HLOC, entire policy202L--Medical Necessity Determinations, Section IV206L—Continued Authorization HLOC, entire policy <p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon policies clearly define and outline the procedures and information needed for initial and continuing authorization of services (see 204L--Intake Data Collection Initial Auth HLOC, entire policy). The first step in the process is to gather the clinical data and determine if medical necessity is being met (see Section IV of 202L--Medical Necessity Determinations and all of 204L--Intake Data Collect Initial Auth HLOC). If additional services are requested, the process for conducting continuing reviews is reflected in 206L--Continued Auth HLOC.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>9. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)(2)(i)</i></p> <p>Contract: Exhibit B-2—None</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 408L Care Management Documentation Audit, entire policy CCM Audit Tools, entire document CSNT 116.6--Inter-Rater Reliability, entire document <p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon has a policy and procedure in place that outlines the process to ensure consistent application of the review for authorizing decisions (see 408L--Care Management Documentation Audit, entire policy). Beacon clinical care managers complete quarterly peer audits utilizing a web-based audit tool that focuses on the content of documentation for UM decision making (see CCM Audit Tools, entire document). The audit reviews inpatient and acute treatment unit (ATU) admissions that occurred the previous quarter. Each CCM has 2 admissions per month that are randomly selected, then their peers review the documentation in Care Connect. Care Connect is Beacon's integrated system for authorization, documentation, and claims management. The cases are selected by the UM Manager and distributed to the CCM team to complete. The web-based tool calculates the scoring for the documentation audit, which includes timeliness of decision making and content elements. If the results of the audit are below the standard of 85% compliance, then a corrective action plan is implemented to improve staff knowledge. Staff must</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>complete the plan and achieve competency. Results are reported to the team and to the Clinical Peer Advisor.</p> <p>Beacon also requires clinical staff to take an annual inter-rater reliability test (IRR) to evaluate the appropriateness of clinical decision-making and to establish a systematic method to monitor the consistency with which clinicians and Peer Advisors apply medical necessity criteria in decision-making and documentation. Clinical staff must achieve a passing score of 80% on this examination; if they do not achieve a passing score, then they must complete a corrective action plan to achieve competency. See CSNT 116.6-Inter-Rater Reliability (entire document).</p> <p>Beacon relies on multiple other methods to ensure consistency in decision-making. These methods include individual and group supervision, weekly rounds, peer audits, and live or recorded call supervision/call monitoring. See CSNT 116.6-Inter-Rater Reliability (entire document).</p>	
<p>10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)(2)(ii)</i></p> <p>Contract: Exhibit B-2—14.8.2.5</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 202L--Medical Necessity Determinations, Section IV, G 303L--Peer Advisor Adverse Determinations, Section IV.A.3 203L--Medical Necessity Determination Timelines, Section IV.A.6. 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon policies direct staff to contact the provider, when necessary, for a review determination. Authorizations or denials of services involve immediate telephonic notification of providers (see Section IV.A.6. of 203L--Medical Necessity Determination Timelines). In addition, Beacon policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial or continued authorization is denied (see Section IV.A.3. of 303L--Peer Advisor Adverse Determinations).</p> <p>If providers fail to request additional services, Beacon staff will reach out to coordinate with the provider to determine whether the member has discharged from care. If there is not enough information available to make a determination, the provider is notified along with details about the information needed. Attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions (see Section IV.A.6. of 203L--Medical Necessity Determinations Timelines).</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member’s medical or BH needs.</p> <p style="text-align: right;"><i>42 CFR 438.210(b)(3)</i></p> <p>Contract: Exhibit B-2—14.6.6</p>	<p>Evidence:</p> <p>1. 303L--Peer Advisor Adverse Determinations, Section II.C</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon policy 303L Peer Advisor Adverse Determinations notes that denial decisions can be made by only qualified Peer Advisors, as defined in Section II.C.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.</p> <p style="text-align: right;"><i>42 CFR 438.210(c)</i></p> <p>Contract: Exhibit B-2—8.6.1 10 CCR 2505-10 8.209.4.A.1</p>	<p>Evidence:</p> <p>1. 203L--Medical Necessity Determination Timelines, Section IV</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care (see Section IV of 203L--Medical Necessity Determination Timelines).</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions:</p> <ul style="list-style-type: none"> For standard authorization decisions—as expeditiously as the member’s condition requires and not to exceed 10 calendar days following the receipt of the request for service. If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the 	<p>Evidence:</p> <p>1. 203L--Medical Necessity Determination Timelines, Section IV</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. In Beacon’s policy titled “203L--Medical Necessity Determination Timelines”, the</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service.</p> <p style="text-align: right;"><i>42 CFR 438.210(d)(1–2)</i></p> <p>Contract: Exhibit B-2—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)</p>	<p>following timeframes are noted for mailing of Notices of Action:</p> <ul style="list-style-type: none"> • All authorization decisions are made as expeditiously as the member's health condition requires (see Section IV, A.2 and B.5). • For standard service authorization decisions that deny or limit services, within 10 calendar days of the receipt of request for service (see Section IV.B.5). • If the provider indicates that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, Beacon's UM team makes an expedited authorization. For expedited decisions, providers are notified by telephone when a decision is made and letters are mailed no later than 72 hours from the receipt of the request for services (see Section IV.B.7). 	
<p>14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if:</p> <ul style="list-style-type: none"> • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. <p style="text-align: right;"><i>42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)</i></p> <p>Contract: Exhibit B-2—8.6.6.1, 8.6.8.1</p>	<p>Evidence:</p> <p>1. 203L--Medical Necessity Determination Timelines, entire policy</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon rarely extends decision timeframes; however, when extensions are made, the policy titled "203L--Medical Necessity Determination Timelines" provides the guidelines that are followed with extended decision timeframes (see Section IV.B.5).</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	Authorization decisions are made as quickly as the member’s health condition requires, but no longer than ten (10) calendar days following the request for service for standard authorization decisions that deny or limit services. The RAE may extend the service authorization notice timeframe up to fourteen (14) additional days if the member or provider requests extension, or if the RAE shows a need for additional information and how the extension is in the member’s best interest. The RAE will give the member written notice of the reason for the extension and the member’s right to file a grievance if they disagree with this extension.	
<p>15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs.</p> <p style="text-align: right;"><i>42 CFR 438.404(a)</i> <i>42 CFR 438.10 (c)</i></p> <p>Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1</p>	<p>Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on denial notices. (Reviewed in Member Information standard.)</p> <p>Evidence:</p> <ol style="list-style-type: none"> 307L_Member Information Requirements_NHP, entire policy *Misc NOABD_NHP, entire document *Misc <p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon follows the policy titled “307L_Member Information Requirements_NHP” when developing member-facing materials. All commonly used</p>	<p>NHP</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>member materials that were originally created in English are translated into Spanish, which has been deemed as a prevalent language by the state. We recognize that a large proportion of Medicaid enrollees have low health literacy, thus we follow guidelines developed by CMS in developing the member materials policy for low literacy readers. For example, when we present a concept that may be unknown to a low literacy reader, we offer a definition in simple language. The Notice of Adverse Benefit Determination (see NOABD_NHP) letter is translated into Spanish, and we are prepared to translate it into other languages, when necessary. We test our materials to ensure they are at or below the 6th grade reading level.</p>	
<p>Findings: NHP policies and template NOABDs demonstrated that notices to members were written in language easy to understand and informed the member of availability of the letter in other languages and alternative formats. However, HSAG found seven of 10 denial record reviews were <i>Not Met</i> for “correspondence with the member was easy to understand.” NHP’s letter incorporated language such as “exclusionary criteria,” “less intensive,” and “less restrictive” to describe the reason for adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.</p>		
<p>Required Actions: NHP must ensure that the NOABD in its entirety is written in language that is easy for a member to understand.</p>		
<p>16. The notice of adverse benefit determination must explain the following:</p> <ul style="list-style-type: none"> The adverse benefit determination the Contractor has made or intends to make. The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of 	<p>Evidence:</p> <ol style="list-style-type: none"> NOABD_NHP, entire document *Misc Appeal Guide_NHP *Misc, entire document 203L--Medical Necessity Determinations Timelines, Section IV.C. 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits).</p> <ul style="list-style-type: none">• The member’s right to request one level of appeal with the Contractor and the procedures for doing so.• The date the appeal is due.• The member’s right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld.• The procedures for exercising the right to request a State fair hearing.• The circumstances under which an appeal process can be expedited and how to make this request.• The member’s rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. <p style="text-align: right;"><i>42 CFR 438.404(b)(1–6)</i></p> <p>Contract: Exhibit B-2—8.6.1.5–8.6.1.12 10 CCR 2505-10 8.209.4.A.2</p>	<p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon ensures that members receive Notices of Adverse Benefit Determination (see NOABD_NHP) that contain all required elements. The content of notifications is identified in policy 203L, Section IV.C.</p> <p>In an effort to only include elements in the letter which pertain specifically to the member in question, the Grievance and Appeal Guide is mailed with every Notice of Adverse Benefit Determination letter. All Notices of Adverse Benefit Determination (NOABD_NHP) include the following information:</p> <ul style="list-style-type: none">• Specific information about the services which have been denied (e.g., level of care, dates of services).• Identification of the person making the determination and his or her credentials.• Explanation of the reasons for denial.• Information about the member’s right to file an appeal, or the provider’s right to file an appeal when the provider is acting on behalf of the member as the member’s Designated Client Representative.• Member’s right to request a State Fair Hearing.• Instructions for filing an appeal or grievance, including due date.	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none">Explains the circumstances under which an expedited resolution of an appeal is available, and how to request it.Explains the member’s right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of continued services.	
<p>17. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language:</p> <ul style="list-style-type: none">A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits.A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated.A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. <p style="text-align: right;"><i>HB19-1269: Section 6—10-16-113 (I), (II), and (III)</i></p> <p>Contract: None</p>	<p>Evidence:</p> <p>1. NOABD_NHP, entire document *Misc</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. All Notices of Adverse Benefit Determination letters (see NOABD_NHP) for denial of behavioral, mental health, or SUD benefits include the following statements in plain language:</p> <ul style="list-style-type: none">A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits.A statement providing information about contacting the office of the ombudsman for	<p><i>For Information Only</i></p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>behavioral health care, if the member believes his or her rights under the MHPAEA have been violated.</p> <ul style="list-style-type: none"> A statement specifying that members are entitled, upon request to the RAE and free of charge, to a copy of the medical necessity criteria for any behavioral, mental health, or SUD benefit. 	
<p>18. The Contractor mails the notice of adverse benefit determination within the following time frames:</p> <ul style="list-style-type: none"> For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). For denial of payment, at the time of any denial affecting the claim. For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. For expedited service authorization decisions, within 72 hours after receipt of the request for service. For extended service authorization decisions, no later than the date the extension expires. For service authorization decisions not reached within the required time frames, on the date the time frames expire. <p style="text-align: right;"><i>42 CFR 438.404(c)</i></p> <p>Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3</p>	<p>Evidence:</p> <p>1. 203L--Medical Necessity Determination Timelines, Section IV</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. In Beacon’s policy titled “Policy 203L--Medical Necessity Determination Timelines”, the following outlines the timeframes noted for mailing of Notices of Action:</p> <ul style="list-style-type: none"> For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 days (see Section IV.K) At the time of the action for denial of payment. (see Section IV.B.4 and Section IV.M) For standard service authorization decisions that deny or limit services, within 10 calendar days of the receipt of request for service (see Section IV.H and Section IV.I) For expedited authorization decisions, within 72 hours (see Section IV.B.7) 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> For extended service authorization decisions, no later than the date the extension expires (see Section IV.F to Section IV.I) For service authorization decisions not reached within the required timeframes, on the date timeframes expire (see Section IV. A.5) 	
<p>19. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except:</p> <ul style="list-style-type: none"> The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: <ul style="list-style-type: none"> The Agency has factual information confirming the death of a member. The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. The member has been admitted to an institution where he/she is ineligible under the plan for further services. The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. 	<p>Evidence:</p> <p>1. 203L--Medical Necessity Determination Timelines, entire policy especially Section IV.B</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. See Section IV.B of 203L--Medical Necessity Determination Timelines.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> – A change in the level of medical care is prescribed by the member’s physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. <p style="text-align: right;">42 CFR 438.404(c) 42 CFR 431.211 42 CFR 431.213 42 CFR 431.214</p> <p>Contract: Exhibit B-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)</p>		
<p>20. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision.</p> <p style="text-align: right;">42 CFR 438.404(c)(4)</p> <p>Contract: Exhibit B-2—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)</p>	<p>Evidence:</p> <p>1. 203L--Medical Necessity Determination Timelines, entire policy</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy details the requirements to send written notification to the member and to carry out the determination as expeditiously as the member’s health condition requires. The written notice also includes information about their right to file a grievance, if he or she disagrees with that decision. Written notification requirements can be found in Beacon’s policy titled “203L--Medical Necessity Determination Timelines” in the following locations:</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • IV.F.3.a • IV.G.3.a • IV.H.2-3 • IV.I.2 • IV.I.3 <p>The policy also outlines the fact that authorization decisions are made as required by the member’s health condition, and no later than the date the extension expires. See the following sections:</p> <ul style="list-style-type: none"> • IV.F.1 • IV.G.1 • V.H.1 • IV.I.1 	
<p>21. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.</p> <p>Contract: Exhibit B-2—14.8.6</p> <p style="text-align: right;"><i>42 CFR 438.210(e)</i></p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. CSNT 117.5 Objectivity in Clinical Decision Making, entire policy <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. (see CSNT 117.5 Objectivity in Clinical Decision Making, entire policy). During new employee orientation and annually thereafter, Beacon staff receives training regarding conflict of interest and employee code of conduct, including signing</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	an annual attestation agreeing with policies that they are not given incentives to deny or limit care for members.	
<p>22. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:</p> <ul style="list-style-type: none"> Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part. <p style="text-align: right;"><i>42 CFR 438.114(a)</i></p> <p>Contract: Exhibit B-2—2.1.33</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 270L--Emergency and Post-Stabilization Services, Section II.A Health First Colorado Member Handbook, p.13 *Misc. Provider Handbook2019_NHP, p.24 *Misc. <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” defines emergency medical conditions that correspond with the State’s definition of this term. Members receive information in the Member Handbook about what defines an emergency or crisis and how to obtain emergency services (see Health First Colorado Member Handbook, page 13). Beacon staff assist members and direct them to the nearest facility/ER when there is any question of an emergency medical condition. The Provider Handbook also includes the following definition (see Provider Handbook2019_NHP, page 24):</p> <p><i>Emergency Services</i> Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>the absence of immediate medical attention could reasonably be expected to result in:</p> <ul style="list-style-type: none">• placing the patient’s health in serious jeopardy• serious impairment to bodily functions• serious dysfunction of any bodily organ or part• Emergency services do not require prior authorization• Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.	
<p>23. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right;"><i>42 CFR 438.114(a)</i></p> <p>Contract: Exhibit B-2—2.1.34</p>	<p>Evidence:</p> <ol style="list-style-type: none">1. 270L--Emergency and Post-Stabilization Services, Section II.C.2. Provider Handbook2019_NHP, p. 24 <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services”, Section II.C, provides this exact definition of Emergency Services. This definition is also given to providers in the Provider Handbook (see Provider Handbook2019_NHP) as follows:</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p><i>Emergency Services</i> Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:</p> <ul style="list-style-type: none"> • placing the patient’s health in serious jeopardy • serious impairment to bodily functions • serious dysfunction of any bodily organ or part • Emergency services do not require prior authorization • Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care. 	
<p>24. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member’s condition.</p> <p style="text-align: right;"><i>42 CFR 438.114(a)</i></p> <p>Contract: Exhibit B-2—2.1.74</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 270L--Emergency and Post-Stabilization Services, Section II.D. Provider Handbook2019_NHP, p.64 *Misc. <p>Narrative:</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” provides this exact definition of post-stabilization services (see Section II.D). This definition is also given to providers in the Provider Handbook (see Provider Handbook2019_NHP):</p> <p><i>Post-stabilization Services:</i> Services that are provided in relationship to an emergency medical condition and are provided after a member is stabilized in order to maintain the stabilized condition.</p>	
<p>25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.</p> <p style="text-align: right;"><i>42 CFR 438.114(c)(1)(i)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.2</p>	<p>Evidence:</p> <p>1. 270L--Emergency and Post-Stabilization Services, Section I.A.</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” (see Section I.A.) provides an overview of how emergency services are covered and reimbursed. Members can access these services without prior authorization and claims for emergency services are accepted and paid for to any provider, regardless of network status.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>26. The Contractor may not deny payment for treatment obtained under either of the following circumstances:</p> <ul style="list-style-type: none"> A member had an emergency medical condition, including cases in which the absence of immediate medical attention would <i>not</i> have had the following outcomes: <ul style="list-style-type: none"> Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part. <p><i>(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)</i></p> <ul style="list-style-type: none"> A representative of the Contractor’s organization instructed the member to seek emergency services. <p style="text-align: right;"><i>42 CFR 438.114(c)(1)(ii)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.6</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 270L--Emergency Post-Stabilization Services, Section I.C.1 <p>Narrative: This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency Post-Stabilization Services” (see Section I.C.1.) clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>27. The Contractor does not:</p> <ul style="list-style-type: none"> Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member’s primary care provider or the Contractor of the 	<p>Evidence:</p> <ul style="list-style-type: none"> 270L--Emergency and Post-Stabilization Services, Section I.D <p>Narrative:</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>member’s screening and treatment within 10 calendar days of presentation for emergency services.</p> <p style="text-align: right;"><i>42 CFR 438.114(d)(1)</i></p> <p>Contract: Exhibit B-2—14.5.7.2.8</p>	<p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” contains the following specific language in Section I.D:</p> <ul style="list-style-type: none"> • Beacon does not: <ul style="list-style-type: none"> • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, Beacon, the Department of the member’s screening and treatment within 10 days of presentation for emergency services. 	
<p>28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.</p> <p style="text-align: right;"><i>42 CFR 438.114(d)(2)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.9</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 270L--Emergency and Post-Stabilization Services, Section I.E. <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. The Beacon policy titled “270L--Emergency and Post-Stabilization Services” releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition (see Section I.E.). The policy states the following:</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> Beacon does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, or for post stabilization services, regardless of whether these services were obtained through COS_EC or not. Members are not charged for these services. 	
<p>29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.</p> <p style="text-align: right;"><i>42 CFR 438.114(d)(3)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.10</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 270L--Emergency and Post-Stabilization-Services, Section I.F <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” (see Section I.F.) states the attending physician/facility makes decisions independent of any contact with the RAE (or Beacon) regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered. The policy states the following:</p> <ul style="list-style-type: none"> Beacon allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	the member is sufficiently stabilized for transfer or discharge, and that determination is binding on COS_EC (Beacon) who is responsible for coverage and payment.	
<p>30. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor’s network of providers.</p> <p><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(i)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.11</p>	<p>Evidence:</p> <p>1. 270L--Emergency and Post-Stabilization Services, Section I.H</p> <p>Narrative: This required element is delegated to Beacon Health Options by NHP. The RAE (or Beacon) is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative, regardless of whether they are provided within or outside of the RAE’s network of providers. Section I.H. of Beacon’s policy titled “270--Emergency and Post-Stabilization Services clearly states this financial responsibility. The policy reads as follows:</p> <ul style="list-style-type: none">• Beacon is financially responsible for post stabilization care services obtained within or outside the network that are:• Pre-approved by a plan provider or a representative of Beacon.• Not pre-approved by a plan provider or Beacon representative but are administered to maintain the member’s stabilized condition within 1 hour	<p>NHP</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>of a request to Beacon for pre-approval of further post stabilization care services.</p> <ul style="list-style-type: none">• Not pre-approved by a plan provider of Beacon representative but are administered to maintain, improve, or resolve the member’s stabilized condition if:• Beacon does not respond to request for pre-approval within 1 hour• Beacon cannot be contacted• Beacon representative and the treating physician cannot reach agreement concerning the member’s care and the Beacon Medical Director is not available for consultation. In this situation, the Beacon representative will assist the treating physician in arranging consultation with the Beacon Medical Director and the treating physician may continue with care of the member until the Beacon Medical Director is reached or any of the following criteria are met, and at this time the financial responsibility of Beacon ends:<ul style="list-style-type: none">• An in network physician with privileges at the treating hospital assumes responsibility for the member’s care• An in network physician assumes responsibility for the member’s care through transfer• A Beacon representative and the treating physician reach an agreement concerning the member’s care• The member is discharged	



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services.</p> <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(ii)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.12</p>	<p>Evidence:</p> <p>1. 270L--Emergency and Post-Stabilization-Services, Section I.H</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further post-stabilization care services. Beacon's policy titled "270L--Emergency and Post-Stabilization Services states the following (see Section I.H.):</p> <ul style="list-style-type: none">• Beacon is financially responsible for post stabilization care services obtained within or outside the network that are:<ul style="list-style-type: none">• Pre-approved by a plan provider or a representative of Beacon.• Not pre-approved by a plan provider or Beacon representative but are administered to maintain the member's stabilized condition within 1 hour of a request to Beacon for pre-approval of further post stabilization care services.• Not pre-approved by a plan provider of Beacon representative but are administered to maintain,	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>improve, or resolve the member’s stabilized condition if:</p> <ul style="list-style-type: none">• Beacon does not respond to request for pre-approval within 1 hour• Beacon cannot be contacted• Beacon representative and the treating physician cannot reach agreement concerning the member’s care and the Beacon Medical Director is not available for consultation. In this situation, the Beacon representative will assist the treating physician in arranging consultation with the Beacon Medical Director and the treating physician may continue with care of the member until the Beacon Medical Director is reached or any of the following criteria are met, and at this time the financial responsibility of Beacon ends:<ul style="list-style-type: none">• An in-network physician with privileges at the treating hospital assumes responsibility for the member’s care• An in-network physician assumes responsibility for the member’s care through transfer• A Beacon representative and the treating physician reach an agreement concerning the member’s care• The member is discharged	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if:</p> <ul style="list-style-type: none">• The organization does not respond to a request for pre-approval within 1 hour.• The organization cannot be contacted.• The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(iii)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.12</p>	<p>Evidence:</p> <p>1. 270L--Emergency and Post-Stabilization Services, Section I.H</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon is financially responsible for post stabilization care services obtained within or outside the network that have not been pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition if the following circumstances are met:</p> <ul style="list-style-type: none">• The RAE's UM delegate (i.e., Beacon) does not respond to a request for pre-approval within one hour.• The RAE's UM delegate cannot be contacted.• The RAE's representative (i.e., Beacon) and the treating physician cannot reach an agreement concerning the member's care and the RAE's Medical Director is not available for consultation. In this situation, the RAE must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with the care of the patient until a plan physician is available to consult on the treatment or until one of the criteria in 422.113 (c)(3) is met.	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
	Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” states this financial responsibility (see Section I.H.).	
<p>33. The Contractor’s financial responsibility for poststabilization care services it has not pre-approved ends when:</p> <ul style="list-style-type: none"> • A plan physician with privileges at the treating hospital assumes responsibility for the member’s care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member’s care, or • The member is discharged. <p style="text-align: right;"><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(3)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.14</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 270L--Emergency and Post-Stabilization Services, Section I.H <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post-Stabilization Services” (see Section I.H) relays financial responsibility for post-stabilization care services that have not been pre-approved ends when the following is met:</p> <ul style="list-style-type: none"> ○ A plan physician with privileges at the treating hospital assumes responsibility for the member’s care; ○ A plan physician assumes responsibility for the member’s care through transfer; ○ The organization’s representative and the treating physician reach an agreement concerning the member’s care; ○ or the member is discharged. 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>34. If the member receives poststabilization services from a provider outside the Contractor’s network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider.</p> <p><i>42 CFR 438.114(e)</i> <i>42 CFR 422.113(c)(iv)</i></p> <p>Contract: Exhibit B-2—14.5.6.2.13</p>	<p>Evidence:</p> <p>1. 270L--Emergency and Post Stabilization Services, Section I.E.</p> <p>Narrative:</p> <p>This required element is delegated to Beacon Health Options by NHP. Beacon’s policy titled “270L--Emergency and Post Stabilization Services” states that members are not charged for post-stabilization services regardless of whether the services are obtained through a network provider or not (see Section I.E.). The policy states the following:</p> <ul style="list-style-type: none">Beacon does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, or for post stabilization services, regardless of whether these services were obtained through Beacon or not. Members are not charged for these services.	<p>NHP</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Results for Standard I—Coverage and Authorization of Services						
Total	Met	=	29	X	1.00	= 29
	Partially Met	=	1	X	.00	= 0
	Not Met	=	0	X	.00	= 0
	Not Applicable	=	4	X	NA	= NA
Total Applicable		=	30	Total Score	=	29
Total Score ÷ Total Applicable						= 97%



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor maintains and monitors a PCMP and BH network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise:</p> <ul style="list-style-type: none"> • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Adult mental health providers • Pediatric mental health providers • SUD providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers • Family planning providers <p style="text-align: right;"><i>42 CFR 438.206(b)(1)</i></p> <p>Contract: Exhibit B-2—9.5.1.1, 9.5.1.3</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. PRCO_003_Network Policy_NHP, sections IV.A-B and V.A 2. R2_NetworkAdequacyPln 07-19 V2_NHP, pg. 1 3. R2_NetworkRpt_Q4FY18-19 V2_NHP, pg. 13, 15 4. ProviderDirectory_NHP, entire document <p>Narrative:</p> <p>All provider network functions of Northeast Health Partners (NHP) are delegated to Beacon Health Options as the administrative services organization for NHP. As provider network functions are delegated to Beacon, its policies and procedures showcase NHPs' adherence to State and federal requirements for access and availability of services; thus, Beacon's policies and procedures are referenced throughout this compliance monitoring tool.</p> <p>Beacon operates according to a policy that outlines the procedures involved to evaluate and maintain a comprehensive provider network. NHPs' provider network serves the needs of all eligible Health First Colorado (Medicaid) members including, those with limited English proficiency or physical or mental disabilities as outlined in the PRCO_003_Network Policy_NHP Section IV.A-B for primary care</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>providers and Section V.A for behavioral health providers.</p> <p>The policy PRCO_003_Network Policy_NHP Section VI.A outlines that the network is monitored “to ensure there is sufficient providers in the network to meet the requirements of the members for access to care to serve primary care and care coordination needs, serve all behavioral health needs, and allow for member freedom of choice” page 5.</p> <p>Beacon maintains a Network Adequacy Plan (see R2_NetworkAdequacyPlan07-19 V2_NHP, pg 1) to monitor development and maintenance of the primary care and behavioral health networks. The review includes the number of providers and specialties. Beacon monitors the availability of providers quarterly as noted in the R2_NetworkRpt_Q4FY18-19 V2_NHP, for primary care providers (pg 13) and behavioral health providers (page 15). The number and diversity of providers included in the network is monitored to serve member needs based on expected population and member’s historic utilization. The network is assessed and monitored on a quarterly basis to identify areas of need. Beacon focuses on provider recruitment based on the findings of the monitoring efforts to maintain sufficient providers within the network.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	Members are provided choice in providers across the NHP region as seen in the see ProviderDirectory_NHP, entire document. The network includes an array of providers who can serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary.	
<p>2. In establishing and maintaining the network adequacy standards, the Contractor considers:</p> <ul style="list-style-type: none"> • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor’s service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. 	<p>Evidence:</p> <ol style="list-style-type: none"> 1. PRCO_003_Network Policy_NHP, section VI.A 1-8 2. R2_NetworkAdequacyPln 07-19 V2_NHP, entire document 3. R2_NetworkRpt_Q4FY18-19 V2_NHP, entire document 4. ProviderDirectory_NHP, entire document 5. Provider Handbook2019_NHP, pg. 16 *Misc. <p>Narrative:</p> <p>Northeast Health Partners (NHP) delegated this function to Beacon Health Options. Beacon operates according to a policy that outlines the procedures involved to establish guidelines to monitor the network. It also establishes elements to consider when evaluating a comprehensive provider network (see PRCO_003_Network Policy_NHP section VI.A 1-8).</p> <p>Further, Beacon maintains a Network Adequacy Plan to address all needs of the NHP network and fill any</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none">The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. <p><i>42 CFR 438.206(a); 438.68(c)(i)–(ix)</i></p> <p>Contract: Exhibit B-2—9.1.4, 9.1.5, 9.1.7.1, 9.5.1.2, 9.5.1.4-6</p>	<p>disparity found (see R2_NetworkAdequacyPln07-19_NHP, entire document). Beacon monitors the network adequacy quarter over quarter as outlined in R2_NetworkRpt_Q4FY18-19 V2_NHP (see entire document) in accordance with the Network Adequacy Plan.</p> <p>On a quarterly basis, the network is monitored for adequacy, through the Network Adequacy Report by reviewing the number of providers by types and specialty (see R2NetworkRptQ4FY18-19 pg. 11-14), providers accepting new members (pg. 14, 17) by geographic location by time and distance to members (pg. 1-3), linguistic and cultural capacity (pg. 16-17), accessible facilities (pg. 15, 17), and use of telemedicine (pg. 5-6) For areas of need identified in the report, Beacon outlines a strategy to fill the disparity and monitors quarter over quarter for effectiveness of strategy of filling the disparity in the provider network. An example is the strategy to work with DHS Department to recruit CORE providers (see R2_NetworkRpt_Q4FY18-19 V2_NHP pg. 6).</p> <p>Beacon audits the availability of providers every quarter as well as annually. The monitoring completed by Beacon includes an assessment of member needs and expected utilization based off historic utilization data and member enrollment. Members can choose any participating behavioral health provider who is licensed, credentialed, contracted with Beacon and</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s) as outlined in Provider Handbook 2019_NHP, pg 16. The provider directory includes a diverse group of providers who can adequately serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary (see ProviderDirectory_NHP entire document).	
<p>3. The Contractor ensures that its PCMP provider network complies with time and distance standards as follows:</p> <ul style="list-style-type: none"> • Adult primary care providers: <ul style="list-style-type: none"> – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: <ul style="list-style-type: none"> – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: <ul style="list-style-type: none"> – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes <p style="text-align: right;"><i>42 CFR 438.206(a); 438.68(b)</i></p> <p>Contract: Exhibit B-2—9.4.7</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. PRCO_003_Network Policy_NHP, section VI.E 2. R2_NetworkRpt_Q4FY18-19 V2_NHP, pg. 1-2 3. R2GeoAccessQ4FY18-19_NHP, entire document <p>Narrative:</p> <p>As the delegated entity for managing the provider network for Northeast Health Partners (NHP), Beacon monitors the provider network time and distance standards on an ongoing basis as outlined in PRCO_003_Network Policy_NHP section VI.E and R2_NetworkRpt_Q4FY18-19 V2_NHP pg 1-3. Beacon monitors time and distance standards and utilizes geoaccess mapping to monitor compliance.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Beacon conducts geoaccess mapping on a quarterly basis to review time and distance standards. Beacon uses the latest Quest Analytics Suite application to calculate the travel distance to the closest PCMP from member residence. Example of the geoaccess review is the R2GeoAccessQ4FY18-19_NHP Entire Document which shows the time and distance analysis of adults in urban county of Weld for primary care providers.</p> <p>All of the pediatric and adult members in region 4 have a choice of at least two (2) PCMPs within the maximum distance for their county classification including the rural and frontier areas (see R2_NetworkRpt_Q4FY18-19 V2_NHP pg 1-2)</p>	
<p>4. The Contractor ensures that its BH provider network complies with time and distance standards as follows:</p> <ul style="list-style-type: none"> • Acute care hospitals: <ul style="list-style-type: none"> – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: <ul style="list-style-type: none"> – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: 	<p>Evidence:</p> <ol style="list-style-type: none"> 1. PRCO_003_Network Policy_NHP section VI. F 2. R2_NetworkRpt_Q4FY18-19 V2_NHP pg 4-5 3. R2GeoAccessQ4FY18-19_NHP entire document <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon manages and monitors the behavioral health provider network time and distance standards on an</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none">– Urban counties—30 miles or 30 minutes– Rural counties—60 miles or 60 minutes– Frontier counties—90 miles or 90 minutes• SUD providers for both adults and children:<ul style="list-style-type: none">– Urban counties—30 miles or 30 minutes– Rural counties—60 miles or 60 minutes– Frontier counties—90 miles or 90 minutes <p><i>Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)</i></p> <p>42 CFR 438.206(a); 438.68(b)</p> <p>Contract: Exhibit B-2—9.4.9</p>	<p>ongoing basis as outlined in PRCO_003_Network Policy_NHP, section VI.F, which details the requirements for the behavioral health provider network to comply with the established time and distance standards.</p> <p>Beacon conducts geoaccess mapping on a quarterly basis to review time and distance standards. Beacon uses the latest Quest Analytics Suite application to calculate the travel distance to the closest behavioral health provider from member residence. Example of the geoaccess review is the R2GeoAccessQ4FY18-19_NHP Entire Document which shows the time and distance analysis of adults in urban county of Weld for behavioral health providers. Geoaccess reports and monitoring confirm that there is an adequate number of Behavioral Health Providers. Results indicate that there is access to providers throughout the RAE region at the maximum distance for their county classification (see R2_NetworkRpt_Q4FY18-19_V2_NHP pg 4-5)</p>	



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>5. The Contractor provides female members with direct access to a women’s health care specialist within the network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health care specialist.</p> <p style="text-align: right;"><i>42 CFR 438.206(b)(2)</i></p> <p>Contract: Exhibit B-2—9.2.7</p>	<p>Evidence:</p> <ol style="list-style-type: none">1. PRCO_003_Network Policy_NHP, section IV.G2. R2_NetworkRpt_Q4FY18-19 V2_NHP, pg. 133. R2_NetworkRpt_Q4FY18-19 V2, Excel Tab Physical Health4. Provider Handbook2019_NHP, pg. 15 *Misc. <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP) Beacon manages its provider network, including contracts with PCMPs that have women’s health care specialist within their practices (see PRCO_003_Network Policy_NHP section IV.G).</p> <p>Beacon monitors network adequacy to ensure female members have direct access to women’s routine, and preventive health care services either as a member’s assigned PCP or network provider.</p> <p>This is accomplished by monitoring the number of providers with provider type Obstetrics/Gynecology. The Network Adequacy Report captures the Provider Type of Obstetrics/Gynecology (see R2_NetworRpt_Q4FY18-19 V2_NHP pg. 13 and R2_NetworkRpt_Q4FY18-19_V2, NHP Excel Tab Physical Health). The majority of providers with the specialty of women’s routine and preventive health</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>care services are reported under adult primary care. The Department has updated the template for second quarter of FY 2020, which will more accurately report providers with specialty for women’s routine and preventive health care services.</p> <p>Additionally, as part of member choice, members may seek services from any primary care provider enrolled with Medicaid including to seek women’s health care (see Provider Handbook 2019_NHP pg 15).</p>	
<p>6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member.</p> <p>Contract: Exhibit B-2—9.7.6</p> <p>42 CFR 438.206(b)(3)</p>	<p>Evidence:</p> <ol style="list-style-type: none">1. Provider Handbook2019_NHP, pg. 14 *Misc.2. Policy 257L_Request for Second Opinion_NHP, Entire Document3. Health First Colorado Member Handbook, pg. 11 *Misc. <p>Narrative:</p> <p>Northeast Health Partners (NHP) delegates this function to Beacon. Beacon has established a policy (see Policy 257L_Request for Second Opinion_NHP). As outlined in the policy, it is essential to determine medical necessity of services provided and allowing members to seek a second opinion. Information for members regarding the process to request a second opinion can be found in the member handbook (Health First Colorado Member Handbook, pg. 11). Providers are educated about the member right and</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	informed that this is completed at no cost to the member (see Provider Handbook 2019_NHP pg. 14).	
<p>7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them.</p> <p style="text-align: right;"><i>42 CFR 438.206(b)(4)</i></p> <p>Contract: Exhibit B-2—14.6.1.1</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 274L_Request for Out of Network Provider Policy_NHP, Entire Policy *Misc. SCA_Letter_Practitioner_NHP, entire document SCA_Letter_Facilities_NHP, entire document Provider Handbook2019_NHP, pg. 15 *Misc. Health First Colorado Member Handbook, pg. 11 *Misc. <p>Narrative:</p> <p>Northeast Health Partners (NHP) delegates this function to Beacon Health Options. Beacon has a policy and procedure specific for the RAE to process requests for covered services through an out of network provider in a timely manner (see 274L_Request for Out of Network Provider_NHP Entire policy). This policy details the approval process and situations for which Single Case Agreements are approved for covered services by an out-of-network provider. In the member handbook, members are informed that they can ask</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>to see a provider who may not be listed in the provider directory (see Health First Colorado Member Handbook, pg. 11*Misc).</p> <p>Providers are sent an individual contract (SCA_Letter_Practitioner_NHP and SCA_Letter_Facilities_NHP). The SCA letters reference the provider handbook that informs providers that they may not bill members for any services covered by Medicaid (see Provider Handbook2019_NHP pg 15).</p>	
<p>8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network.</p> <p>Contract: Exhibit B-2—14.7.11.1</p> <p>42 CFR 438.206(b)(5)</p>	<p>Evidence:</p> <ol style="list-style-type: none">1. Provider Handbook2019_NHP, pg. 55-56 *Misc.2. SCA_Letter_Practitioner_NH, pg. 13. SCA_Letter_Facilities_NHP, entire document4. NM306.3_SCA Contract Negotiation_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners (NHP) delegates this function to Beacon Health Options. Beacon Health Options requires that all out-of-network providers coordinate with Beacon in regard to payment. As included in the provider handbook (see Provider Handbook2019_NHP pg. 55-56), providers are informed that they are not able to balance bill members for Medicaid covered services. Providers are</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>limited in charging Medicaid members for established co-pays for services received and cannot bill members directly for any services rendered.</p> <p>Beacon has a policy and procedure to contract and negotiate fee schedules (payment) for out-of-network providers approved for a Single Care Agreement (see NM306.3_SCA Contract Negotiation_NHP entire document). Beacon’s team managing the Single Case Agreement coordinates rate negotiation with the Director of Provider Relations, to ensure it is within Colorado Medicaid rates. For Medicaid members, this process ensures the cost to the member is no greater than services furnished within the network.</p> <p>As included in the individual single case contract (see SCA_Letter_Practitioner_NHP Pg 1 and SCA_Letter_Facilities_NHP entire document), providers are informed and required to agree to the terms of the agreement which details that the provider cannot hold the member financially liable for any portion of received services that are covered by Medicaid.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.</p> <p>Contract: 9.5.1.1, 9.5.1.3.10</p>	<p>Evidence:</p> <ol style="list-style-type: none">PRCO_003_Network Policy_NHP, section IV.A.4R2_NetworRpt_Q4FY18-19 V2_NHP, pg. 13R2_NetworkRpt_Q4FY18-19 V2, Excel Tab Physical HealthProvider Handbook2019_NHP, pg. 15 *Misc. <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon contracts with PCMPs that include family planning providers within their practices (see PRCO_003_Network Policy_NHP, Section IV.A.4). Beacon monitors the network to ensure that there is access to family planning providers either as a member's assigned PCP or in-network provider.</p> <p>Beacon monitors network adequacy to ensure that there is access to family planning providers. The Network Adequacy Report captures the Provider Type of Obstetrics/Gynecology based on licensure (see R2_NetworRpt_Q4FY18-19_V2_NHP pg. 13 and R2_NetworkRpt_Q4FY18-19_Excel Tab Physical Health). The majority of providers with the specialty for family planning are reported under adult primary care.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	Additionally, as part of member choice, members may seek services from any primary care provider enrolled with Medicaid to seek family planning services (see Provider Handbook2019_NHP pg 9).	
<p>10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows:</p> <ul style="list-style-type: none"> Emergency BH care: <ul style="list-style-type: none"> By phone within 15 minutes of the initial contact. In-person within 1 hour of contact in urban and suburban areas. In-person within 2 hours of contact in rural and frontier areas. Urgent care within 24 hours from the initial identification of need. Non-urgent symptomatic care visit within 7 days after member request. Well-care visit within 1 month after member request. Outpatient follow-up appointments within 7 days after discharge from hospitalization. Members may not be placed on waiting lists for initial routine BH services. <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(i)</i></p> <p>Contract: Exhibit B1—9.4.13</p>	<p>Evidence:</p> <ol style="list-style-type: none"> Provider Handbook2019_NHP, pg. 22, 23-24 *Misc. Webinar Training_051719_NHP, pg. 39-41 PRCO_003_Network Policy_NHP, section VI.C R2_Access to Care Audit_BH_NHP, entire document PNC_Minutes_09132019_NHP, entire document PNC_Minutes_01092019_NHP, entire document BH Access to Care_Webpage_NHP, entire document <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon Health Options establishes policies (PRCO_003_Network Policy_NHP section VI.C) to ensure that our behavioral health network meets</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>expectations for timely access to care and services. Behavioral health providers are required to meet the standards for timely access to care and services. The requirements are outlined in the provider handbook (see Provider Handbook2019_NHP, pg 23-24).</p> <p>In addition to the provider handbook, provider training was offered on May 17, 2019 that covered behavioral health access to care standards. (Webinar Training_051719_NHP, pg 39-41).</p> <p>Beacon monitors adherence to access to care standards by performing outbound calls to practices to audit appointment availability (see R2_Access to Care Audit_BH Entire Document). Results are scheduled to be shared with Provider Network Sub-Committee (PNC) in third quarter 2020. Providers are informed of these administrative audits through the Provider Handbook (see Provider Handbook2019_NHP, pg 22).</p> <p>Additionally, the RAE website link https://www.northeasthealthpartners.org/providers/clinical-tools/ shares link on Access to Care Standards (see BH Access to Care_Webpage_NHP).</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	The Provider Network Adequacy Plan is reviewed by the Provider Network Sub-Committee (PNC) to ensure that providers are meeting access and availability standards and to monitor improvements in any previously identified gaps (see PNC_Minutes_09132019_NHP and PNC_Minutes_01092019_NHP).	
<p>11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides:</p> <ul style="list-style-type: none"> • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(ii)</i></p> <p>Contract: Exhibit B-2—9.4.2–9.4.4</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. PRCO_003_Network Policy_NHP, section VI.B 2. Provider Handbook2019_NHP, pg. 22 *Misc. <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon Health Options requires providers to meet minimum hours of operation, extended hours on evening and weekends, and alternatives to emergency department visits. Providers serving Medicaid beneficiaries are required to offer Medicaid beneficiaries comparable hours of operation to commercial members. Beacon has a policy and procedure where this is outlined (see PRCO_003_Network Policy_NHP section VI.B).</p> <p>This requirement is communicated to all providers through the provider handbook, which is an extension</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	of the provider’s contract with Beacon for NHP (see Provider Handbook2019_NHP pg 22).	
<p>12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary.</p> <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(iii)</i></p> <p>Contract: Exhibit B-2—9.4.6</p>	<p>Evidence:</p> <ol style="list-style-type: none"> PRCO_003_Network Policy_NHP, section VI.B.1-2 Provider Handbook2019_NHP, pg. 22 *Misc. <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon Health Options requires providers to maintain emergency coverage 24 hours a day, seven (7) days a week. The policy PRCO_003_Network Policy_NHP section VI.B 1-2 outlines the requirement. Providers are communicated about the requirement through the See Provider Handbook2019_NHP pg. 22, which is an extension of the provider’s contract with Beacon for NHP network.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>13. The Contractor ensures timely access by:</p> <ul style="list-style-type: none"> Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. Monitoring network providers regularly to determine compliance. Taking corrective action if there is failure to comply. <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(iv)–(vi)</i></p> <p>Contract: Exhibit B-2—9.5.1.8</p>	<p>Evidence:</p> <ol style="list-style-type: none"> Provider Handbook2019_NHP, pg. 22 *Misc. PRCO_003_Network Policy_NHP, section VII. D R2_NetworkRpt_Q4FY18-19 V2_NHP, pg. 11 Medicaid Access to Care Standards_NHP, entire document 	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>5. R2_Acces to Care Audit_BH_NHP, entire document</p> <p>6. R2_Acces to Care Audit_PCP_NHP, entire document</p> <p>Narrative:</p> <p>Northeast Health Partners (NHP) delegated this function to Beacon Health Options. As a result, Beacon established a system to monitor timely access to care for members. As outlined in the policy and procedure, Beacon conducts outbound calls to practices to audit appointment availability (see PRCO_003_Network Policy_NHP section VII. D). Providers are informed of the administrative audits through the provider handbook (see Provider Handbook2019_NHP pg. 22). Additionally, PCPs received a reminder about the access to care standards as noted in the Medicaid Access to Care Standards_NHP attachment (see entire document).</p> <p>Beacon Health Options performs ongoing monitoring to ensure providers are meeting requirements for access to care. All PCPs are audited every six months starting in June 2019. Five percent (5%) of the behavioral health provider network within the region will be audited each month on rotating basis starting in December 2019, after PRCO_003_Network Policy_NHP was effectuated. Providers that do not</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>meet standards receive education and are reviewed within 90 days of initial contact to ensure compliance is achieved (see PRCO_003_Network Policy_NHP section VII. D).</p> <p>All PCPs were audited in June/July of 2019 as a beta test to the audit workflow including survey questions and a tracking system. These updates were incorporated for the behavioral health audit conducted in December 2019 when the finalized policy was approved (see PRCO_003_Network Policy_NHP Entire Document). This included an improved script for the outbound calls and tracking system of responses. Based on the audit in June/July 2019, 61% of the PCP practice locations contracted had an appointment available within seven (7) days for new patient and routine appointment (see R2_NetworkRpt_Q4FY18-19 V2_NHP pg. 11). During the December 2019 audit for PCP, 57% of respondents met all appointment availability standards (see R2_Access to Care Audit_PCP_NHP entire document).</p> <p>For behavioral health providers, the initial 5% of behavioral health provider locations in the region were audited in December 2019 with 50% of the provider having same day and routine appointment availability, and 17% had availability for a new member. The results showed that 33% compliance of</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>all the standards. (See R2_Access to Care Audit_BH_NHP Entire Document).</p> <p>All PCP and behavioral health providers audited will receive communication of the audit results. Providers will receive an audit within 90 days of notice to monitor compliance.</p>	
<p>Findings: NHP submitted its provider manual, Access to Care Standards Training Webinar, and BH Access to Care webpage to demonstrate efforts to educate the provider network on the required State standards for timely access to care and services. NHP implemented a phone survey of a small sample of the behavioral health network to evaluate the availability and timeliness of RAE member appointments. The December 2019 survey results illustrated that all of the standards were met by one of the seven providers surveyed. Of the six providers that did not have access, two providers did not have appointment availability for new members, two providers did not have same day or routine appointment availability for established members, and the remaining three providers were nonresponsive to NHP’s outreach attempts.</p>		
<p>Required Actions: NHP must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). NHP must also ensure implementation of CAPs for providers that are not in compliance with the access to care standards.</p>		
<p>14. The Contractor participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes:</p> <ul style="list-style-type: none"> • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: <ul style="list-style-type: none"> – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. 	<p>Evidence:</p> <ol style="list-style-type: none"> 1. Provider Handbook2019_NHP, pg. 31, 87 *Misc. 2. Webinar Training_051719_NHP, pg. 2-38 3. ProviderDirectory_NHP, entire document 4. 311L Responding to Member Requests with Limited English Speaking Skills_NHP, entire policy *Misc. 5. Health First Colorado Member Handbook Spanish, entire document *Misc. 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none">– Medical risks associated with the member population’s racial, ethnic, and socioeconomic conditions.• Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members.• Providing language assistance services for all Contractor interactions with members. <p>Contract: Exhibit B-2—7.2.1–7.2.6</p> <p>42 CFR 438.206(c)(2)</p>	<p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon Health Options requires all physical and behavioral health services to be offered in a culturally competent manner.</p> <p>The provider handbook outlines the requirements for serving members in a culturally competent manner including sensitivity to the member’s particular language barriers, cultural beliefs, values and disabilities (see Provider Handbook2019_NHP pg 31, 87) in addition to principles for considering sex and gender identity (see pg. 87). Beacon makes critical written materials available in Spanish and English and links members with interpreter services by contacting Member Engagement Specialist (see 311L Responding to Member Requests with Limited English Speaking Skills_NHP and Health First Colorado Member Handbook Spanish, Entire Document)</p> <p>Provider webinar training was offered on May 17, 2019. It covered cultural competency with the topics of (a) reducing health disparities by addressing cultural diversity, (b) clear communication and working with individuals with limited English Proficiency, (c) discussing various populations and subcultures, and (d) seniors and people with</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>disabilities. It also included resources for language assistance and how to identify member's language proficiency (see Webinar Training_051719_NHP pg 2-38).</p> <p>Members are able to find network providers that have cultural competency training via the provider directory (see ProviderDirectory_NHP) and they can contact Member Services for assistance.</p>	
<p>15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities.</p> <p>Contract: Exhibit B-2—9.1.4.5, 9.1.7.1, 9.5.1.2</p> <p>42 CFR 438.206(c)(3)</p>	<p>Evidence:</p> <ol style="list-style-type: none">1. ProviderDirectory_NHP, entire document2. Provider Handbook2019_NHP, pg. 23*Misc.3. ACC DCC Assessment Tool_NHP, entire document <p>Narrative:</p> <p>On behalf of Northeast Health Partners (NHP), Beacon Health Options requires providers to maintain an accessible facility. Provider Relations offers assessments of facilities upon request (see Provider Handbook2019_NHP, pg. 23). Provider Relations utilizes a standard tool for this assessment (see ACC DCC Assessment Tool_ NHP, Entire Document). Members are able to find network providers who are ADA compliant via the provider directory</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	(ProviderDirectory_NHP, entire document) and they can also contact Member Services for assistance.	
<p>16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</p> <ul style="list-style-type: none">• A Network Adequacy Plan is submitted to the State annually.• A Network Adequacy Report is submitted to the State quarterly. <p>Contract: Exhibit B-2—9.5.1–9.5.4</p>	<p>Evidence:</p> <ol style="list-style-type: none">1. R2_NetworkAdequacyPln 07-19 V2, entire document2. R2_NetworkRpt_Q4FY18-19 V2_NHP, entire document <p>Narrative:</p> <p>The RAE has submitted in a timely manner and in the format specified by the State an annual Network Adequacy Plan to the State (R2_NetworkAdequacyPln 07-19 V2 Entire Document). Similarly, the Network Adequacy Report is submitted one month after the end of each quarter (R2_NetworkRpt_Q4FY18-19 V2_NHP Entire Document).</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Results for Standard II—Access and Availability									
Total	Met	=	15	X	1.00	=	15		
	Partially Met	=	1	X	.00	=	0		
	Not Met	=	0	X	.00	=	0		
	Not Applicable	=	0	X	NA	=	NA		
Total Applicable		=	16		Total Score	=	15		
Total Score ÷ Total Applicable						=	94%		



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals.</p> <p style="text-align: right;"><i>42 CFR 438.400(b)</i> <i>42 CFR 438.402(a)</i></p> <p>Contract: Exhibit B2—8.1 10 CCR 2505-10—8.209.1</p>	<p>Note: Federal requirements related to appeals apply only to MCOs and PIHPs (BH services of RAEs). The contract requires that regulations related to grievances apply to all RAE members.</p> <p>Evidence:</p> <ol style="list-style-type: none"> 1. Complaint Delegation and Procedures_NHP, entire document 2. 305L_Appeal Policy_NHP, entire policy 3. 303L_Grievance Policy_NHP entire policy 4. Complaint Guide_NHP, entire document 5. Appeal Guide_NHP, entire document *Misc 6. State Fair Hearing Guide_NHP, entire document 7. NOABD_NHP, pages 3-8 *Misc 8. Complaint Receipt Letter_NHP, entire document 9. Appeal Receipt Letter_NHP, entire document 10. Appeal Decision Letter_NHP, entire document 11. Appeal Job Aid_NHP, entire document 12. Complaint Job Aid_NHP, entire document 13. Provider Handbook2019_NHP, pages 12, 15-19 *Misc 14. R2_GrieveAppealQ4_FY18-19 Summary, entire document 15. Meeting Minutes Example_NHP, pages 2-3 16. Evidence of Accepted_Grievance and Appeal Report_NHP, entire document 17. R2_GrieveAppealQ4_FY18-19_NHP, entire document <p>Description of Process:</p> <p>Northeast Health Partners (NHP) delegates the oversight of its grievance and appeal system to Beacon Health Options. Beacon has</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>a grievance and appeals system in place for members in the NHP region. Beacon developed a Complaint Delegation and Procedures document which outlines the responsibilities of Beacon and the responsibilities of Advocates at the community mental health centers in handling grievances. See Complaint Delegation and Procedures_NHP, entire document.</p> <p>Beacon staff lead a quarterly Member Services Subcommittee with the community mental health center advocates to discuss complaint operations and to ensure fidelity to the complaint process. Beacon has a Member Engagement Specialist who is available to train the community mental health center staff on the complaint requirements as well as documenting in Beacon's feedback database. See Meeting Minutes Example_NHP, pages 2-3.</p> <p>Beacon follows their 305L_Appeal Policy_NHP to process any appeal that a Member, Legal Guardian, or Designated Client Representative (DCR) initiates following the receipt of a Notice of Adverse Benefit determination for any denied behavioral health service.</p> <p>Beacon follows 303L_Grievance Policy_NHP that outlines the grievance process for Members, Legal Guardians or DCRs. The policy outlines that a grievance can be made for any behavioral or physical health service other than an adverse benefit determination notification.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Beacon developed a Complaint Job Aid and an Appeal Job Aid_NHP to operationalize the systems of handling complaints and appeals. See Complaint Job Aid_NHP, entire document and Appeal Job Aid_NHP, entire document.</p> <p>Beacon developed and implemented a Complaint Guide, an Appeal Guide, and a State Fair Hearing guide to assist members and providers with the procedures to make a complaint, request an appeal, or request a State Fair Hearing. See Complaint Guide_NHP, entire document, Appeal Guide_NHP, entire document, and State Fair Hearing Guide_NHP, entire document. These guides can be found on our website, www.northeasthealthpartners.org:</p> <p>Complaint Guide_NHP</p> <p>Appeal Guide_NHP</p> <p>State Fair Hearing Guide_NHP</p> <p>The appeal process is outlined in the Notice of Adverse Benefit Determination letter which is sent to a member when there is any denial in behavioral health services. See NOABD_NHP, pages 3-8. If a member, legal guardian, or DCR requests an appeal, Beacon sends a receipt notification letter within two (2) business days and includes the Appeal Guide. See Appeal Receipt Letter_NHP, entire document. If an appeal is upheld, Beacon will send the State Fair Hearing Guide with the appeal determination letter so that Members know their right to request a State Fair Hearing. See Appeal Decision Letter_NHP, entire document.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>NHP sends a complaint receipt letter within two (2) business days when a member files a complaint. NHP attaches the complaint guide with the receipt letter so members have information about what to expect when filing a complaint. See Complaint Receipt Letter_NHP, entire document.</p> <p>Beacon educates providers on the grievance and appeal process through the Provider Handbook2019_NHP. See Provider Handbook2019_NHP, pages, 12, 15-18.</p> <p>Beacon uses a feedback database to collect and track complaints and compliments. Advocates at the community mental health centers have access to the feedback database and are responsible for entering in processed complaints on a monthly basis. See Complaint Job Aid_NHP, entire document for a detailed explanation of the processes we use to collect complaint information.</p> <p>Beacon collects and tracks appeals in our secure file storage system which includes all of the information that members would want considered in their appeal.</p> <p>Beacon submits all appeals and grievances in a quarterly report to Healthcare, Policy and Financing (HCPF) forty-five days after the end of the quarter. In this report, we track the totals of all complaints and appeals. See R2_GrieveAppealQ4_FY18-19_NHP, entire document, and R2_GrieveAppealQ4_FY18-19 Summary_NHP, entire document. HCPF sends a response if the grievance and appeal report was accepted, accepted with changes, or rejected. For evidence that all of the grievance and appeal reports</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	have been accepted, please see Accepted_Grievance and Appeal Report_NHP, entire document.	
<p>2. The Contractor defines adverse benefit determination as:</p> <ul style="list-style-type: none"> The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service. The denial, in whole, or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. The denial of a member’s request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). <p style="text-align: right;"><i>42 CFR 438.400(b)</i></p>	<p>Inform plan on-site that proposed federal rule changes include: Clarification that denial, in whole or in part, of a payment for a service does not include denial of a claim because it is not a “clean claim” and is not an adverse benefit determination.</p> <p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 3-5 303L_Grievance Policy_NHP, pages 2-4 274L_Request for Out of Network Provider Policy_NHP *Misc, page 1 and 2 Provider Handbook2019_NHP, page 78 *Misc Appeal Guide_NHP, pages 1-2 *Misc <p>Narrative:</p> <p>Northeast Health Partners (NHP) has the definition of an adverse benefit determination located in internal and external documents which include the required definitions as well as the definition in 42 CFR 438.400 which states that members who live in rural locations can exercise their right to obtain services outside of the network.</p> <p>Internally, Beacon follows the grievance policy and the appeals policy which has the full definition of an Adverse Benefit Determination for all staff to follow. See 305L_Appeal Policy_NHP, pages 3-5 and 303L_Grievance Policy_NHP pages 2-4.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>Contract: Exhibit B2—2.1.3 10 CCR 2505-10—8.209.2.A</p>	<p>Beacon follows the 274L_ Request for Out of Network Provider Policy_NHP which outlines the single case agreement process. The policy describes the procedures Beacon will follow when Members request seeing an out-of-network provider, including members living in rural communities who want to exercise their right to obtain services outside of the network. See 274L_ Request for Out of Network Policy, page. 1 and 2.</p> <p>Externally, NHP has an appeal guide available for members which has a simplified definition of adverse benefit determination. This is located on our website, Appeal Guide_NHP, and is sent to members with the Appeal Receipt Letter. See Appeal Guide_NHP, page 1-2. Beacon has a Provider Handbook2019_NHP posted on the website available to providers that has the definition of an adverse benefit determination. See Provider Handbook2019_NHP, page 78.</p>	
<p>3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination.</p> <p style="text-align: right;"><i>42 CFR 438.400(b)</i></p> <p>Contract: Exhibit B2—2.1.5 10 CCR 2505-10—8.209.2.B</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, page 3 303L Grievance Policy, page 2 IIA Appeal Guide_NHP, pages 1-2 *Misc Provider Handbook2019_NHP, page 79 *Misc Appeal And Complaint Training_NHP, Slide 3 <p>Narrative:</p> <p>NHP defines “Appeal” as a review by the RAE of an adverse benefit determination made by the RAE. This definition is outlined in Beacon’s policies and procedures as this is a delegated function. See</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>305L_Appeal Policy_NHP, page 3 and 303L_Grievance Policy on page 2. This definition of an appeal is communicated to members through the Appeal Guide (see Appeal Guide_NHP, pages 1-2) and to providers through the Provider Handbook2019_NHP (see page 79).</p> <p>Beacon developed a training on appeals and grievances for use with internal staff and external providers that is completed on an annual basis. The definition of an appeal can be found in this training. See Appeal And Complaint Training, Slide 3.</p>	
<p>4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.</p> <p style="text-align: right;"><i>42 CFR 438.400(b)</i></p> <p>Contract: Exhibit B2—2.1.42, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 303L_Grievance Policy_NHP page 2 305L_Appeal Policy_NHP, page 6 Complaint Guide_NHP, page, page 1 Appeal Extension Letter_NHP, page 2 Quick Appeal Denied Request_NHP, page 2 Appeal and Complaint Training_NHP, slide 9 Provider Handbook2019_NHP, page 15 *Misc <p>Narrative:</p> <p>NHP defines grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. This definition is outlined in Beacon's policies as this is a delegated function. See 303L_Grievance Policy_NHP page 2 and 305L_Appeal Policy_NHP, page 6.</p> <p>Members can find the definition of a grievance in the complaint guide. NHP has simplified the definition to incorporate plain</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>language guidelines in the Complaint Guide. The Complaint Guide can be found on our website. See Complaint Guide_NHP, page 1.</p> <p>NHP notifies members that they can file a grievance if they disagree with NHPs’ decision to extend the time frame to make an appeal authorization decision. See Appeal Extension Letter_NHP, page 2. NHP notifies members verbally and in written format that they can file a grievance if a member’s request for an expedited appeal is denied. See Quick Appeal Denied Request_NHP, page 2.</p> <p>NHP has developed an annual training for internal staff and external providers on the definition of a grievance. See Appeal and Complaint Training_NHP, slide 9.</p> <p>The definition of a grievance can be found in the Provider Handbook2019_NHP. See Provider Handbook2019_NHP, page 15.</p>	
<p>5. The Contractor has provisions for who may file:</p> <ul style="list-style-type: none"> • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member’s written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. <p><i>Note: Throughout this standard, when the term “member” is used it includes providers and authorized representatives (with the exception</i></p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 305L_Appeal Policy_NHP, page 1 IA, C, page 5 E 2. 303L Grievance Policy, page 1, Id, page 2 IIC 3. NOABD_NHP, pages 3, 4, 7, 8 *Misc 4. Provider Handbook2019_NHP, pages 15-16 *Misc 5. Complaint Guide_NHP, page 1 6. Appeal Guide_NHP, page 2 *Misc 7. State Fair Hearing Guide_NHP, pages 1-2 <p>Narrative:</p> <p>NHP has provisions for who can file a grievance, appeal, or a State Fair Hearing. NHP allows anyone to act on a member’s behalf as</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p><i>that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).</i></p> <p style="text-align: right;"><i>42 CFR 438.402(c)</i></p> <p>Contract: Exhibit B2—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5</p>	<p>long as the member has authorized the individual to act as their Designated Client Representative (DCR) in writing.</p> <p>As this is a delegated function, NHP follows Beacon's 303L_Grievance Policy which states that anyone, including a health care professional, may act as a representative as long as the member names them in writing. See 303L_Grievance Policy_NHP pages 1 and 2.</p> <p>NHP also follows Beacon's 305L Appeals Policy which outlines that members, guardians, or a member's DCR have the right to initiate an appeal or State Fair Hearing as long as members have signed a DCR form or it is in writing. See 305L_Appeal Policy_NHP, pages 1 IA, C, Page 5 E.</p> <p>The Designated Client Representative (DCR) Form is located on NHPs' website which members can use to designate a representative to act on their behalf. See DCR Form_NHP. Members can sign this form designating an individual to act on their behalf in the grievance, appeal, or State Fair Hearing process. Members are made aware of this right in the Complaint Guide, Appeal Guide, and State Fair Hearing Guide. See Complaint Guide_NHP, page 1, Appeal Guide_NHP, page 2, and State Fair Hearing Guide_NHP, pages 1-2.</p> <p>Members are sent a Notice of Adverse Benefit Determination (NOABD) Letter when services have been denied for behavioral health treatment. The letter outlines that a member, guardian, or someone they designate can request an appeal on their behalf. The letter notes that if a member designates their provider to file an appeal on their behalf, that provider cannot request continuation of services. See NOABD_NHP, pages 3, 4, 7, and 8.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>NHP developed an Appeal Guide and a State Fair Hearing Guide that states that members can ask for continuation of services during their appeal. We outline that providers cannot ask for continuation of services on a member's behalf in these guides. See Appeal Guide_NHP, page 5 and State Fair Hearing Guide_NHP, page 2.</p> <p>Beacon educates providers on who can file an appeal or grievance in the Provider Handbook2019_NHP. See Provider Handbook2019_NHP, pages 15-16</p>	
<p>6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.</p> <p style="text-align: right;"><i>42 CFR 438.406(a)</i></p> <p>Contract: Exhibit B2—8.3 10 CCR 2505-10 8.209.4.C</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, page 7, IV A 3 a 303L_Grievance Policy_NHP, page 1 Ie 311L_Responding to Member Requests with Limited English 311L Responding to Member Requests with Limited English Speaking Skills_NHP, page 2 *Misc NOADB_NHP, page 3 *Misc Complaint Guide_NHP, page 2 Appeal Guide_NHP, pages 3-4 *Misc Complaint Receipt Letter_NHP, page 1 and 2 Appeal Receipt Letter_NHP, page 2 <p>Narrative:</p> <p>NHP assists members who request help with completing any forms and/or using any auxiliary aids for both grievances and appeals. As this is a delegated function, NHP follows Beacon's policies which outline that we will assist members with filling out forms or</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>providing interpreter services at member's request. Please see 305L_Appeal Policy_NHP, page 7 and 303L_Grievance Policy_NHP, page 1. NHP also follows Beacon's 311L Responding to Member Requests with Limited English Speaking Skills policy to link members with interpreter services. See 311L_Responding to Member Requests with Limited English Speaking Skills_NHP, page 2.</p> <p>NHP developed a complaint guide and an appeal guide to educate members on how NHP will assist them with filling out any forms related to their grievance or appeal as well as helping members utilize interpreter services. See Complaint Guide_NHP, page 2 and Appeal Guide_NHP, pages 3-4. These guides are kept on the NHP website and are mailed to members with the Complaint Receipt Letter and Appeal Receipt Letter. NHPs' toll free numbers and TTY/TTD numbers are provided in these letters. Beacon has a Member Engagement Specialist who will link members with any interpreter services that members request. See Complaint Receipt Letter_NHP, pages 1 and 2 and Appeal Receipt Letter_NHP, page 2.</p>	
<p>7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who:</p> <ul style="list-style-type: none"> Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. Have the appropriate clinical expertise, as determined by the State, in treating the 	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 5D, 7B, 9E 1 303L Grievance Policy, page 7 #11 Complaint Guide_NHP, page 2 Appeal Guide_NHP, page 4 *Misc NOABD_NHP, pages 4, 5, 8 *Misc Appeal Decision Letter_NHP, page 2 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>member’s condition or disease if deciding any of the following:</p> <ul style="list-style-type: none"> – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. <p style="text-align: right;"><i>42 CFR 438.406(b)(2)</i></p> <p>Contract: Exhibit B2—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E</p>	<p>7. Quick Appeal Denied Request_NHP, page 2 8. Appeal Receipt Letter_NHP, page 2 9. Complaint Receipt Letter_NHP, page 2 10. Appeal Job Aid_NHP, pages 3, 11</p> <p>Narrative:</p> <p>Northeast Health Partners ensures that the individuals who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. NHP also ensures that these individuals have the appropriate clinical expertise to make a decision.</p> <p>As this is a delegated function, NHP follows Beacon’s 305L Appeal Policy which defines a Peer Advisor as a health professional employed or contracted with the RAE (see page 5). The Peer Advisor has a current and active, unrestricted license to practice medicine or a health profession. The Peer Advisor is board certified and in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment and is not the individual who made the original non-certification nor the subordinate of one who made decision. Peer advisors are the individuals who review denial decisions. On page 7, the policy outlines that a request for an expedited appeal will be reviewed with a Peer Advisor. On page 9, the policy outlines the types of appeals that the Peer Advisor will review. See 305L_Appeal Policy_NHP, pages 5, 7, and 9. NHPs’ appeal decision letter has a standard paragraph with an attestation that the Peer Advisor was not involved</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>in NHPs’ original determination and documents the scope of the Peer Advisor’s licensure. See Appeal Decision Letter_NHP, page 2.</p> <p>NHP follows Beacon’s 303L Grievance Policy which states that the staff person investigating the grievance shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making, nor are they a subordinate of that individual and who have the appropriate clinical expertise in treating the client’s condition if deciding a grievance that involves clinical issues. See 303L_Grievance Policy_NHP page 7.</p> <p>Beacon developed an Appeal Job Aid_NHP which demonstrates the process staff follow when we receive a request for an expedited appeal and who can process the appeal. NHPs’ Member Engagement Specialist will review the request with the medical director to see if the request meets criteria for an expedited request. If the medical director does not believe that it meets requirements, the member will receive a Quick Appeal Denied Request letter. The letter explains qualifications for the person who reviewed the request for the expedited appeal and the member’s right to file a grievance about the denied request. See Appeal Job Aid_NHP, pages 3, 11. See Quick Appeal Denied Request_NHP, page 2.</p> <p>NHP sends a Complaint Receipt Letter and an Appeal Receipt letter within two (2) business days of receipt of the complaint or appeal. The letter outlines that the person who will investigate the complaint or review the appeal will be a person who was not associated with their situation. See Complaint Receipt Letter_NHP, page 2 and Appeal Receipt Letter_NHP, page 2. NHP sends a</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Complaint Guide and an Appeal Guide in these letters which also explains that those who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making for the member nor a subordinate of that individual. These guides can be found on our website. See Complaint Guide_NHP, page 2 and Appeal Guide_NHP, page 4.</p> <p>NHP sends a Notice of Adverse Benefit Determination letter (NOABD) when there is any denial of coverage. The letter explains that the person who makes a decision regarding an appeal or complaint was not involved in the original decision, nor a subordinate of that individual and will have the necessary clinical experience. See pages NOABD_NHP, pages 4, 5, 8.</p>	
<p>8. The Contractor ensures that the individuals who make decisions on grievances and appeals:</p> <ul style="list-style-type: none"> Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. <p style="text-align: right;"><i>42 CFR 438.406(b)(2)</i></p> <p>Contract: Exhibit B2—None</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 2G, page 7c 303L_Grievance Policy_NHP, Page 7 #11 NOABD_NHP, page 4 *Misc Appeal Decision Letter_NHP, page 2 Complaint Guide_NHP, page 2 Complaint Receipt Letter_NHP, page 2 Appeal Receipt Letter_NHP, page 2 Appeal Guide_NHP, page 5 *Misc Evidence of Request for Records_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners ensures that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>the member or the member’s representative without regard if the information was submitted or considered in the initial adverse benefit determination.</p> <p>As this is a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP and 303L_Grievance Policy. These policies outline procedures that those who make decisions on grievances or appeals will take into account all information provided by the member. See 305L_Appeal Policy_NHP, pages 2 and 7 and 303L_Grievance Policy_NHP page 7.</p> <p>Members are made aware that they can provide additional information for their complaint or appeal in the Complaint Guide and Appeal Guide. See Complaint Guide_NHP, page 2 and Appeal Guide_NHP, page 5. These guides are sent along with the complaint receipt letter and appeal receipt letter. See Complaint Receipt Letter_NHP, page 2 and Appeal Receipt Letter_NHP, page 2. The guides can also be found on the NHP website at www.northeasthealthpartners.org. Members are also informed that they can provide information for an appeal in the Notice of Adverse Benefit Determination letter. See NOABD_NHP, page 4.</p> <p>To demonstrate that NHP takes into account all comments, documents, records, and other information submitted by the member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination (see Evidence of Request for Records_NHP, entire document). NHP’s Member Engagement Specialist compiles all information received from member/DCR into a secure file storage system. This information is sent to the Peer Advisor who reviews</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	all of the information that the member wants considered in the appeal. The Peer Advisor makes a determination to uphold or overturn the denial based on the information reviewed. The member is informed of the information used in making the appeal decision in the appeal decision letter. See Appeal Decision Letter_NHP, page 2.	
<p>9. The Contractor accepts grievances orally or in writing.</p> <p style="text-align: right;"><i>42 CFR 438.402(c)(3)(i)</i></p> <p>Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.D</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 303L Grievance Policy, - pages 1 Ic, 5-6 IV2 2. Complaint Guide_NHP, pages 1, 2 3. NOABD_NHP, page 8 *Misc 4. Provider Handbook2019_NHP, page 15 *Misc 5. Ice Cream and Info Flyer_NHP, entire document 6. Appeal And Complaint Training_NHP slides 9, 10 <p>Narrative:</p> <p>Northeast Health Partners will accept a grievance orally or in writing. As a delegated function, NHP follows Beacon's 303L_Grievance Policy which states that grievances can be filed orally or in writing. See 303L_Grievance Policy_NHP pages 1 and 6. Members can file a grievance at their community mental health center or be directed to contact NHPs' Member Engagement Specialist to assist in the grievance.</p> <p>Members are informed that they can file a grievance orally or in writing in NHPs' Complaint Guide. See Complaint Guide_NHP, page 1 and 2. This Complaint Guide can be found on NHP's website. See www.northeasthealthpartners.org. This information is also listed in the Notice of Adverse Benefit Determination Letter. See NOABD_NHP, page 8.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Members are also made aware of their right to file a grievance orally or in writing at outreach events which NHP hosts to make members aware of their rights and responsibilities. See Ice Cream and Info Flyer_NHP, entire document.</p> <p>NHPs' Member Engagement Specialist also provides an annual training for staff who work in Beacon's Call Center. The staff are educated on members' rights to make a grievance in writing or verbally. See Appeal and Complaint Training_NHP, slides 9, 10</p> <p>Providers are made aware that Members can file a grievance orally or in writing in the Provider Handbook2019_NHP. See Provider Handbook2019_NHP, Page 15.</p>	
<p>10. Members may file a grievance at any time.</p> <p style="text-align: right;"><i>42 CFR 438.402(c)(2)(i)</i></p> <p>Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.A</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 303L_Grievance Policy_NHP page 1 Ic Complaint Guide_NHP, Page 1 and 2 NOABD_NHP page 8 *Misc Provider Handbook2019_NHP, page 15 *Misc Appeal and Complaint Training_NHP, Slide 11 Example of Complaint Received_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners allows members to file a grievance at any time. As a delegated function, NHP follows Beacon's 303L_Grievance Policy which states that members can file a grievance at any time. See 303L_Grievance Policy_NHP page 1.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Members are made aware of this right to make a complaint at any time in NHPs’ Complaint Guide. See Complaint Guide_NHP, page 1 and 2. This guide is on NHPs’ website, www.northeasthealthpartners.org. This information is included in NHP’s Notice of Adverse Benefit Determination Letter. See NOABD_NHP, page 8.</p> <p>NHPs’ Member Engagement Specialist also provides an annual training for staff who work in Beacon’s Call Center. The staff are educated on members’ rights to make a grievance at any time. See Appeal and Complaint Training_NHP, slide 11.</p> <p>Providers are made aware that members can make a grievance at any time in the Provider Handbook2019_NHP. See Provider Handbook2019_NHP, page 15.</p> <p>For an example of a grievance that can be file at any time, please see <u>Example of Complaint Received_NHP</u>, entire document.</p>	
<p>11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt.</p> <p style="text-align: right;"><i>42 CFR 438.406(b)(1)</i></p> <p>Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.B</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 303L_Grievance Policy_NHP page 6 #5 Complaint Guide_NHP, page 2 Complaint Job Aid_NHP, page 3 Member Complaint Contact Record_NHP, entire document Feedback Database_NHP, entire document Complaint Receipt Letter_NHP, entire document R2_GrieveAppealQ4_FY18-19 Summary_NHP, page 6 <p>Narrative:</p> <p>Northeast Health Partners sends members a written acknowledgement letter within two (2) working days of the receipt</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>of the grievance. As a delegated function, NHP follows Beacon’s 303L_Grievance Policy which states that NHP will send out an acknowledgement letter within two working days. See 303L_Grievance Policy_NHP page 6. NHP’s Member Engagement Specialist and community mental health center Advocates follow NHPs’ Complaint Job Aid which outlines the requirement to send an acknowledgement letter within two (2) working days to members. The date that the acknowledgment letter is sent is recorded in the feedback database. The Member Engagement Specialist audits the feedback database to ensure that acknowledgement letters are being sent within two business days. See Complaint Job Aid_NHP, page 3. For an example of the letter that is sent, please see Complaint Receipt Letter_NHP.</p> <p>The date the grievance is received sets the clock for the two-day turnaround time to send an acknowledgment letter. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. This date is logged in the member’s Complaint Contact Record which is kept in a secure file storage system. The complaint receipt date is also logged into Beacon’s feedback database. See Member Complaint Contact Record_NHP, entire document.</p> <p>The feedback database includes required fields for the date that the complaint was received and the date that the acknowledgement letter was sent. See Feedback Database_NHP, entire document. NHP sends quarterly reports to Colorado’s Department of Healthcare, Policy, and Financing (HCPF). For evidence that we are at 100% compliance in this area, please see R2_GrieveAppealQ4_FY18-19 Summary_NHP, page 5.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	NHP developed a Complaint Guide for members which outlines what members can expect when they make a complaint which includes a written receipt letter from NHP. See Complaint Guide_NHP, page 2.	
<p>12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance.</p> <ul style="list-style-type: none"> Notice to the member must be in a format and language that may be easily understood by the member. <p style="text-align: center;"><i>42 CFR 438.408(a) and (b)(1) and (d)(1)</i></p> <p>Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D</p>	<p>Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on grievance resolution notices. (Reviewed in Member Information standard.)</p> <p>Evidence:</p> <ol style="list-style-type: none"> 303L Grievance Policy, page 7 #12, 7 #13 307L Member Information Requirements_NHP, page 1 *Misc Complaint Job Aid_NHP, pages 3 - 7 Complaint Guide_NHP, pages 2-3 Complaint Receipt Letter_NHP, page 2 Complaint Resolution Letter_NHP, entire document Feedback Database Summary_NHP, entire document R2_GrieveAppealQ4_FY18-19 Summary_NHP, page 5 Complaint Flow Chart_NHP <p>Narrative:</p> <p>Northeast Health Partners aims to resolve each grievance and provide notice to the Member of the resolution of their grievance as expeditiously as possible. This resolution time frame is within 15 working days from the receipt of the grievance. There are times for which NHP may need to extend this time frame at the member's request or because NHP needs more time to resolve a grievance.</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The date the grievance is received establishes the clock for investigating and resolving the grievance. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The 15 working days is used to investigate the complaint such as gathering facts, consulting with others, and reviewing policies. When a resolution is found, the person handling the grievance notifies the member by letter. See Complaint Resolution Letter_NHP, entire document.</p> <p>As a delegated function, NHP follows Beacon’s 303L_Grievance Policy which outlines that those resolving grievances will attempt to resolve the grievance as expeditiously as possible and within the state and federal regulations of fifteen (15) working days. See 303L_Grievance Policy_NHP page 7. The Member Engagement Specialist and/or Advocates who help to resolve the complaint follow the Complaint Job Aid_NHP which outlines the fifteen (15) day business day timeframe. See Complaint Flow Chart_NHP, entire document and Complaint Job Aid_NHP, pages 3-4.</p> <p>NHP developed a Complaint Guide to educate members on the timeframes to resolve their complaint. See Complaint Guide_NHP, pages 2-3. NHP also sends out a Complaint Receipt Letter which states the date that we hope to have a resolution to the complaint. See Complaint Receipt Letter_NHP, page 2.</p> <p>NHP follows Beacon’s 307L Member Information Requirements policy to guide the content in the Complaint Resolution Letter. The Complaint Resolution Letter is written at an appropriate reading level and in a format to be easily understood by members. See</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>307L_Member Information Requirements, page 1. Beacon’s Complaint Job Aid outlines the process to write a resolution letter that is easily understood by the member. See Complaint Job Aid_NHP, pages 4-7.</p> <p>NHP tracks the number of days it takes to resolve a grievance in the feedback database. See Feedback Database Summary_NHP, entire document. NHP sends HCPF a quarterly report which documents the number of business days to resolve a grievance. See R2_GrieveAppealQ4_FY18-19 Summary_NHP, page 5.</p>	
<p>Findings: NHP’s <i>Grievance Policy</i>, related procedures, and <i>Compliant Guide</i> for members all required resolution of complaints within 15 working days, and on-site grievance record reviews confirmed 100 percent compliance with the 15-day time frame. NHP’s template complaint resolution letter was written in language easy for the member to understand. However, HSAG found during grievance record reviews that one resolution letter processed by a delegated entity used language such as “reiterated” and “regional organization,” which would not be easily understood by a member with limited reading ability.</p>		
<p>Required Actions: NHP must develop a mechanism to ensure that each grievance resolution letter is written in language easy for a Medicaid member to understand.</p>		
<p>13. The written notice of grievance resolution includes:</p> <ul style="list-style-type: none"> Results of the disposition/resolution process and the date it was completed. <p>Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.G</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 303L_Grievance Policy_NHP, page 7 #14b and d Complaint Resolution Letter_NHP, entire document Complaint Job Aid_NHP, page 4 <p>Narrative:</p> <p>Northeast Health Partners sends a resolution letter which includes the disposition/resolution of the member’s grievance as well as the</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>date the grievance was resolved. See Complaint Resolution Letter_NHP, entire document.</p> <p>As a delegated function, NHP follows Beacon’s 303L_Grievance Policy which states that we will include the disposition/resolution as well as date of resolution in the letter which is sent to the member. See 303L_Grievance Policy_NHP, page 7.</p> <p>The Member Engagement Specialist and/or Advocates who process complaints follow the Complaint Job Aid which states that the results of the grievance and the date it was completed should be sent in a complaint resolution letter. See Complaint Job Aid_NHP, page 4.</p>	
<p>14. The Contractor may have only one level of appeal for members.</p> <p style="text-align: right;"><i>42 CFR 438.402(b)</i></p> <p>Contract: Exhibit B2—None</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, page 1 Appeal Guide_NHP, page 1 *Misc Appeal Decision Letter_NHP, pages 3-4 Provider Handbook2019_NHP, page 17 *Misc Appeal Job Aid_NHP, page 2 <p>Narrative:</p> <p>Northeast Health Partners has delegated behavioral health appeals to Beacon Health Options. Beacon has only one level of an appeal for the member.</p> <p>Beacon follows the 305 L Appeals Policy which states that there is only one level of an appeal for a member. See 305L_Appeal Policy_NHP, page 1. Beacon follows an Appeal Job Aid_NHP</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>which outlines the procedures for resolving member appeals and states that there is only one level of appeal for members. See Appeal Job Aid_NHP, page 2</p> <p>NHP has developed an appeal guide to educate members that there is only one level of an appeal. See Appeal Guide_NHP, page 1. Beacon sends an appeal decision letter to a member after an appeal decision is made. The letter outlines the next steps members can take if they are in disagreement with the appeal decision letter. The letter explains that members can request a State Fair Hearing with the Administrative Law Judge. See Appeal Decision Letter_NHP, pages 3-4.</p> <p>Beacon developed and maintains a Provider Handbook2019_NHP which states that members will have only one (1) level of appeal at the regional organization. See Provider Handbook2019_NHP, page 18.</p>	
<p>15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice.</p> <p style="text-align: right;"><i>42 CFR 438.402 (c)(2)(ii)</i></p> <p>Contract: Exhibit B2—8.7.5.1 10 CCR 2505 10 8.209.4.B</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 1 I A, 6 IV 2, 8Cb Appeal Guide_NHP, page 2, 3 *Misc NOABD_NHP, page 4 *Misc Appeal Not Processed_NHP, entire document Provider Handbook2019_NHP, page 16 *Misc <p>Narrative:</p> <p>Northeast Health Partners allows members, legal guardians, or a DCR to file an appeal with NHP within 60 calendar days from the</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>date on the Notice of Adverse Benefit Determination Letter. NHP outlines the date that a member can request an appeal in the Notice of Adverse Benefit Determination letter. This letter is a primary way that members know that they can request and appeal and the time frame to request an appeal. See NOABD_NHP, page 4.</p> <p>Beacon follows the 305L_Appeal Policy_NHP which states that members can file an appeal within sixty (60) calendar days. See 305L Appeal Policy, pages 1, 6, and 8. When Beacon receives an appeal request, the Member Engagement Specialist will ascertain if the appeal was received within the 60-day time frame. If a member, legal guardian or DCR requests an appeal outside of the 60-day time frame, the Member Engagement Specialist will send a letter stating that the appeal was not processed and the reason it was not processed. See Appeal Not Processed_NHP, entire document.</p> <p>NHP developed an Appeal Guide which outlines that members have sixty (60) days to file a complaint. This guide can be found on NHP's website, www.northeasthealthpartners.org. See Appeal Guide_NHP, page 2, 3.</p> <p>Beacon developed and maintains a Provider Handbook2019_NHP which explains that members have sixty (60) days to file an appeal. See Provider Handbook2019_NHP, page 16.</p>	
<p>16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution).</p> <p style="text-align: right;"><i>42 CFR 438.402(c)(3)(ii)</i></p> <p>Contract: Exhibit B2—8.7.5.2 10 CCR 2505-10 8.209.4.F</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 1, IA, Page 6 IV 2 Appeal Guide_NHP, page 4 *Misc NOABD_NHP, page 4 *Misc Appeal Request Letter_NHP, entire document Expedited Appeal Workflow, entire document 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>6. Appeal Job Aid_NHP, pages 2-3</p> <p>Narrative:</p> <p>Northeast Health Partners allows members to file an appeal either orally or in writing. The Member Engagement Specialist informs members that any oral standard appeal request needs to be followed up with in writing.</p> <p>Beacon follows the 305L_Appeal Policy_NHP which states that a member can request an appeal orally or in writing. The policy states that if a verbal request is made for a standard appeal, the member will need to follow up this appeal request in writing; however, members do not need to follow up in writing for an expedited appeal request. See 305L Appeals Policy, pages 1, 6.</p> <p>NHP educates members that they can request an appeal orally or in writing through several avenues. NHP sends a Notice of Adverse Benefit Determination letter which states that members can request an appeal orally or in writing. See NOABD_NHP, page 4. NHP developed an Appeal Guide which states that a member can file an appeal orally or in writing. See Appeal Guide_NHP, page 4. This guide is located on NHPs' website, www.northeasthealthpartners.org.</p> <p>NHPs' Member Engagement Specialist manages all behavioral health appeals received from members. The Member Engagement Specialist follows the Appeal Job Aid which states that any verbal request for an appeal needs to be followed up in writing. Part of the protocol is to educate the member that NHP needs for the member</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>to follow up their verbal request in writing. See Appeal Job Aid_NHP, pages 2-3. When a member requests an appeal verbally, we make attempts to obtain their signed request by sending an Appeal Request Letter_NHP with the appeal receipt letter or by contacting the member telephonically. See Appeal Request Letter_NHP.</p> <p>The Member Engagement Specialist uses the Appeal Job Aid_NHP which states that an expedited verbal appeal request does not need to be followed up in writing and a verbal standard appeal request needs to be followed up with a written request. See Appeal Job Aid_NHP, pages 2-3 and Expedited Appeal Workflow_NHP.</p>	
<p>17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution.</p> <p style="text-align: right;"><i>42 CFR 438.406(b)(1)</i></p> <p>Contract: Exhibit B2—8.1, 8.7.2 10 CCR 2505-10 8.209. 4.D</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 3 II A, 7 #4, 12 J3 Appeal Guide_NHP, page 3, 4 *Misc Appeal Receipt Letter_NHP, entire document Grievance Appeal Report_NHP, page 12 Denied Expedited Appeal Request, entire document Appeal Job Aid_NHP, pages 9-10 <p>Narrative:</p> <p>The Member Engagement Specialist sends the member a written acknowledgement of an appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. For an example of the template letter sent, please see Appeal Receipt Letter_NHP, entire document.</p> <p>NHP follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. As a delegated</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>function, NHP follows Beacon’s 305L_Appeal Policy_NHP which states that we will send an acknowledgement letter within two (2) working days from the date that we receive the standard appeal request. See 305L_Appeal Policy_NHP, pages 3, 7, 12.</p> <p>The date the appeal is received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. Since appeals can be filed orally but must be followed with a written request for standard appeals, the date of first contact is the date that starts the “appeal clock.” If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. The Member Engagement Specialist documents the appeal receipt date in Beacon’s Connects System. The Member Engagement Specialist sends an Appeal Receipt Letter to the member. See Appeal Receipt Letter_NHP, entire document.</p> <p>If a member is requesting an expedited appeal, the Member Engagement Specialist will follow the Appeal Job Aid_NHP and review with the Medical Director. See Appeal Job Aid_NHP, pages 9-10. If the Medical Director denies the expedited appeal request, the Member Engagement Specialist will send a Denied Expedited Appeal Request letter which explains that their appeal will be treated like a standard appeal and requires the request in writing. See Denied Expedited Appeal Request, entire document.</p> <p>NHP developed an Appeal Guide which states what the member can expect from NHP when they file an appeal. NHP lists that the member can expect to receive an Appeal Receipt letter within two (2) business days. See Appeal Guide_NHP, page 3 and 4.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	NHP sends a quarterly report to HCPF which documents compliance with sending an appeal acknowledgement letter within two (2) workings days. See Grievance Appeal Report_NHP, page 12.	
<p>18. The Contractor’s appeal process must provide:</p> <ul style="list-style-type: none"> • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: <ul style="list-style-type: none"> – The member and his or her representative, or – The legal representative of a deceased member’s estate. <p style="text-align: right;"><i>42 CFR 438.406(b)(3) and (6)</i></p> <p>Contract: Exhibit B2—8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209. 4.F, 8.209.4.I</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 305L_Appeal Policy_NHP, pages 1 IA, 6 IV 2, 7 #3f 2. Appeal Guide_NHP, pages 4, 5 *Misc 3. Appeal Receipt Letter_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners’ appeal process provides for members, guardians, Designated Client Representatives, or the legal representative of a deceased member’s estate to request an appeal verbally once they have been notified of an Adverse Benefit Determination. NHP follows state and federal regulations to ensure that members/guardians/DCRs can exercise all of their rights in the appeal process and that members have all access to appropriate files, can present evidence to substantiate their appeal, and that oral inquiries will be treated as an appeal to establish the earliest filing date.</p> <p>NHPs’ Member Engagement Specialist explains all of the rights to the member when they call to request an appeal. The Member Engagement Specialist communicates to the member/guardian/DCR of the limited time frames in making an appeal decision.</p> <p>NHP follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>outlines that verbal standard appeal requests are treated as appeals to establish the earliest filing date on pages 1 and 6. The policy states that a member can request an appeal orally or in writing. The policy states that if a verbal request is made for a standard appeal, the member will need to follow up this appeal request in writing. The policy outlines that expedited requests do not need to be followed up in writing on page 6. The policy outlines that members, their representative, or the legal representative of a deceased member's estate are parties of the appeal on page 7. See 305L_Appeal Policy_NHP, pages 1, 6, 7.</p> <p>The date the appeal is received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. Since appeals can be filed orally but must be followed with a written request for standard appeals, the date of first contact is the date that starts the “appeal clock.” If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. The Member Engagement Specialist documents the appeal receipt date in Beacon's Connect System and sends out an appeal receipt letter. See Appeal Receipt Letter_NHP, entire document.</p> <p>NHP developed an Appeal Guide which outlines who can request an appeal on a member's behalf. NHP lists that guardians, a designated client representative, or a legal representative of a deceased person's estate can request an appeal. See Appeal Guide_NHP, pages 4, 5.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>19. The Contractor’s appeal process must provide:</p> <ul style="list-style-type: none"> The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) The member and his or her representative the member’s case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. <p style="text-align: right;"><i>42 CFR 438.406(b)(4-5)</i></p> <p>Contract: Exhibit B2—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L Appeal Policy, pages 2G, 2H, 7 #3c Appeal Guide_NHP, page 5 *Misc NOABD_NHP, pages 3, 4 *Misc Appeal Job Aid_NHP, page 3, 10 Appeal Receipt Letter_NHP, page 2 Example of Collecting Appeal Data_NHP, entire document Appeal Decision Letter_NHP, page 2 <p>Narrative:</p> <p>Northeast Health Partners’ appeal process ensures that the member has a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments when they request an appeal. NHP informs the member of the limited time available to receive this information, especially in the case of an expedited appeal request.</p> <p>NHPs’ appeal process also ensures that the member and his or her representative know what is in the member’s case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated in connection with the appeal. If a member requests these records, this information is provided free of charge and sufficiently in advance of the appeal resolution time frame.</p> <p>As this is a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which outlines the information we will obtain from the member to take into consideration for the appeal as well as the information we will provide to the member upon</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>request within a reasonable time frame of the appeal resolution. See 305L_Appeal Policy_NHP pages 2 and 7.</p> <p>Members are made aware that they can provide additional information for their appeal as well as the limited time that they may have to provide this information in the Appeal Guide. Members are made aware that they can request their records used for the appeal in the appeal guide and appeal receipt letter. See Appeal Guide_NHP, page 5 and Appeal Receipt Letter_NHP, entire document. The Appeal Guide is sent with the appeal receipt letter. The guide can also be found on the website at www.northeasthealthpartners.org. Members are also informed that they can provide information for an appeal in the Notice of Adverse Benefit Determination letter and that they can request the records used in making the appeal. See NOABD_NHP, pages, 3, 4.</p> <p>The Member Engagement Specialist follows the Appeal Job Aid_NHP which has a check list to ensure that we communicate the limited time frame that members or their representatives have to provide any information which they would like considered for their appeal. See Appeal Job Aid_NHP, page 3.</p> <p>To demonstrate that NHP takes into account all comments, documents, records, and other information submitted by the member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination, see Example of Collecting Appeal Data_NHP. The Member Engagement Specialist compiles all information received from the member/DCR into a secure file storage system. This information is sent to the Peer Advisor. Also, in NHPs' Appeal Decision Letter, there is standard wording to show what information was used in making the appeal decision. See Appeal Decision Letter_NHP, page 2.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member’s life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor’s expedited review process includes that:</p> <ul style="list-style-type: none"> The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member’s appeal. <p style="text-align: right;"><i>42 CFR 438.410(a–b)</i></p> <p>Contract: Exhibit B2—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 5 F, 7 B, 10 #6 Appeal Guide_NHP, page 4 *Misc NOABD_NHP *Misc, page 5 Provider Handbook2019_NHP, page 28 *Misc <p>Narrative:</p> <p>Northeast Health Partners maintains an expedited review process for appeals for when we determine, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member’s life. NHP ensures that punitive action is not taken against a provider who requests an expedited appeal or supports an appeal on a member’s behalf.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which highlights that the RAE maintains an expedited review process for appeals when the provider or RAE believe that a standard decision could jeopardize the member’s life on pages 5 and 7. On page 10, the policy outlines that we do not take punitive action against a provider acting on the member’s behalf. See 305L_Appeal Policy_NHP pages 5, 7, 10.</p> <p>NHP notifies members of their right or their designated representative’s right to request an expedited appeal in the Notice of Adverse Benefit Determination Letter. The letter indicates that there is no punitive actions if their provider requests an expedited appeal on their behalf. See NOABD_NHP, page 5. This portion of the letter explains that members can request a quick appeal if they</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>or their health care provider believe that waiting ten (10) business days for NHP to decide their appeal would put their health at risk.</p> <p>NHP developed an Appeal Guide which informs members who can request an appeal on their behalf and that they or their DCR can request an expedited appeal if they believe that waiting for a decision will be harmful to their health. See Appeal Guide_NHP, page 4.</p> <p>The provider handbook outlines that Beacon cannot refuse to contract or terminate existing contractual relationships with a behavioral health provider who advocates on a member's behalf. See Provider Handbook2019_NHP, page 28.</p>	
<p>21. If the Contractor denies a request for expedited resolution of an appeal, it must:</p> <ul style="list-style-type: none"> Transfer the appeal to the time frame for standard resolution. Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. <p style="text-align: right;"><i>42 CFR 438.410(c)</i></p> <p>Contract: Exhibit B2—8.7.14.2.2 10 CCR 2505-10 8.209.4.S</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 7-8 B Appeal Guide_NHP, page 4 *Misc Denied Expedited Appeal Request, entire document, Appeal Job Aid_NHP, pages 3, 11 NOABD_NHP, page 5 *Misc Denied Expedited Request Example_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners has a protocol in place to transfer a denied expedited appeal request into standard time frames. NHPs' Member Engagement Specialist contacts the member when there is a denied expedited appeal request and explains the transfer to a standard time frame to make an appeal decision. Members are notified by letter when their request for an expedited appeal is</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>denied. See Denied Expedited Appeal Request, entire document. In this letter we explain that we will transfer the appeal to the timeframe for standard resolutions and that they can file a grievance if they are in disagreement with the denial to expedite their appeal. For an example of a sent letter in which we document the date the member was contacted via phone, see Example of Expedited Appeal Request_NHP, entire document.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP. The policy outlines that any denied expedited appeal request will be transferred to standard appeal timeframes. The policy also outlines the procedures to communicate the denied expedited request to the member and the member’s right to file a grievance about the denied expedited appeal request. See 305L_Appeal Policy_NHP, pages 7-8.</p> <p>NHP developed an Appeal Job Aid_NHP which outlines that the appeal will be transferred to the timeframe of a standard resolution if an expedited request is denied. See Appeal Job Aid_NHP, pages 3, 11.</p> <p>NHP developed an Appeal Guide which outlines what happens when a request for an expedited appeal is denied. See Appeal Guide_NHP, page 4. The appeal guide can be found on our website, www.northeasthealthpartnerships.org.</p> <p>NHP sends members a Notice of Adverse Benefit Determination letter whenever there is a denial of behavioral health services. The letter outlines that when there is a request for an expedited appeal and the expedited time frame request is denied, that the appeal</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	decision will be transferred to the standard appeal time frame. The Member Engagement Specialist attempts to communicate verbally and will send a letter of this denied expedited appeal request. The letter also states that a member can make a complaint if they are unhappy with the decision to deny an expedited request. See NOABD_NHP, page 5	
<p>22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames:</p> <ul style="list-style-type: none"> For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. Written notice of appeal resolution must be in a format and language that may be easily understood by the member. <p style="text-align: right;"><i>42 CFR 438.408(b)(2)</i> <i>42 CFR 438.408(d)(2)</i> <i>42 CFR 438.10</i></p> <p>Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1</p>	<p>Inform the health plan on-site that proposed federal rule changes include to eliminate the 18-point requirement for taglines on appeal resolution notices. (Reviewed in Member Information standard.)</p> <p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 2 E, 4 #5b, 10 F 1a, 11 G1 Appeal Guide_NHP, pages 3 *Misc Provider Handbook2019_NHP, page 18 *Misc Appeal Receipt Letter_NHP, page 2 Appeal Decision Letter_NHP, entire document Appeal Job Aid_NHP, pages 3, 11-13 R2_GrieveAppealQ4_FY18-19_NHP, entire document 307L_Member Information Requirements_NHP, pages 1, 3 *Misc <p>Northeast Health Partners aims to make a decision on each appeal and provides notice to the member of the resolution of their appeal as expeditiously as the member's health condition requires. This resolution time frame is within ten (10) working days from the receipt of the appeal. There are times that NHP may need to extend</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>this time frame at the member's request or because NHP needs more time to resolve an appeal.</p> <p>The date the appeal is received establishes the clock for resolving the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The ten (10) working days is used to collect information to be used in the appeal decisions.</p> <p>As a delegated function, NHP follows Beacon's 305_Appeals Policy which outlines that those making appeal decisions will attempt to resolve the appeal as expeditiously as the member's health condition requires or within the ten (10) working days of receipt of the appeal. The policy states that the written notification to the member must be in a format easily understood by the member. See 305L_Appeal Policy_NHP, pages 2, 10, 11. The Member Engagement Specialist follows the Appeal Job Aid_NHP which outlines the ten (10) day business day time frame and standards to review the letter to ensure that it is easily understood. See Appeal Job Aid_NHP, page 3.</p> <p>NHP developed an Appeal Guide to educate members on the timeframes to make an appeal decision. See Appeal Guide Guide_NHP, page 3. NHP also sends out an Appeal Receipt Letter which states the date that we hope to have an appeal decision. See Appeal Receipt Letter_NHP, page 2.</p> <p>NHP follows Beacon's 307L_Member Information Requirements policy to guide the content in the Appeal Decision Letter. The Appeal Decision Letter is written at an appropriate reading level and</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>in a format to be easily understood by members. The Appeal Job Aid_NHP outlines the process for the readability testing to ensure that the letter can be easily understood by the member. The decision letter needs to be sent to the supervisor for approval prior to sending out the letter to the member. See 307L_Member Information Requirements_NHP, pages 1, 3. See Appeal Job Aid_NHP, pages 11-13.</p> <p>NHP sends members an Appeal Decision Letter within ten (10) working days of the member filing the appeal. See Appeal Decision Letter_NHP, entire document.</p> <p>NHP sends HCPF a quarterly report which documents NHPs' compliance of sending out the appeal decision letter within ten (10) business days. See R2_GrieveAppealQ4_FY18-19_NHP, entire document.</p> <p>Beacon educates providers on the timeframes used for appeal decisions in the Provider Handbook2019_NHP. See Provider Handbook2019_NHP, page 18.</p>	
Findings: While NHP's <i>Appeal Policy</i> , related procedures, and <i>Appeal Guide</i> for members, all required resolution of complaints within 10 working days, HSAG found during on-site appeal record reviews that one case was <i>Not Met</i> for resolution of a standard appeal within the required time frame. In addition, HSAG found that one appeal resolution letter included clinical acronyms regarding alternative therapies—e.g., “MST”—that would not be easy for the member to understand.		
Required Actions: NHP must ensure that all standard appeal decisions are made within 10 working days from receipt of the appeal, unless the decision time frame is extended. In addition, NHP must ensure that information in the appeal resolution letter does not include clinical information that would be difficult for a member to understand.		



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal.</p> <ul style="list-style-type: none">For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. <p><i>42 CFR 438.408(b)(3) and (d)(2)(ii)</i></p> <p>Contract: Exhibit B2—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L</p>	<p>Evidence:</p> <ol style="list-style-type: none">305L_Appeal Policy_NHP, pages 4 #5c, 7B, 10 #7, 10 F 1cAppeal Guide_NHP, page 3 *MiscAppeal Decision Letter_NHP, entire documentAppeal Job Aid_NHP, pages 2-3. <p>Narrative:</p> <p>Northeast Health Partners resolves each expedited appeal and provides written notification within seventy-two (72) hours of receipt of the expedited appeal. See Appeal Decision Letter_NHP, entire document. NHPs' Member's Engagement Specialist also makes reasonable efforts to notify the member of the appeal resolutions.</p> <p>As a delegated function, NHP follows Beacon's 305 L_Appeals Policy which outlines that expedited appeal requests will be resolved within seventy-two (72) hours after the RAE receives the appeal. The policy also states that the RAE will make reasonable efforts to provide oral notification of the expedited appeal resolution. See 305L_Appeal Policy_NHP, pages 4, 7, 10.</p> <p>NHP developed an Appeal Guide which list what members can expect when they make an expedited appeal request. The guide explains that NHP will make a decision within seventy-two (72) hours for an expedited appeal request. See Appeal Guide_NHP, page 3.</p> <p>The Member Engagement Specialist follows the Appeal Job Aid_NHP which outlines the processes for both approved and denied expedited appeal requests. See Appeal Job Aid_NHP, pages 2-3.</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
Findings: NHP's <i>Appeal Policy</i> and related procedures described resolution of expedited appeal decisions with 72 hours of receipt. NHP's appeal documentation system noted both the time and date of the appeal request and resolution notice. However, during on-site appeal record reviews, HSAG found one expedited appeal in which the member was promptly notified verbally of the decision but NHP failed to send the written resolution to the member within the 72-hour time frame.		
Required Actions: NHP must develop a mechanism to ensure that written notice to the member of an expedited appeal decision is sent within 72 hours of receipt of the appeal request.		
<p>24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if:</p> <ul style="list-style-type: none"> The member requests the extension; or The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. <p style="text-align: right;"><i>42 CFR 438.408(c)(1)</i></p> <p>Contract: Exhibit B2—8.7.14.2, 8.7.14.2.4, 8.5.6 10 CCR 2505-10 8.209.4.K, 8.209.5.E</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 2 E, 2 F1, 7 #3d, 9 #5 303L_Grievance Policy_NHP page 8 #15a-b Appeal Guide_NHP, pages 3-5 *Misc Complaint Guide_NHP, page 3 Appeal Extension Letter_NHP, entire document Complaint Delay Letter_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners can extend the time frames for resolution of grievances or appeals (both expedited and standard appeals) by up to 14 calendar days when a member requests the extension or when NHP believes that there is a need for additional information and communicates how the delay in making a decision would be in the member's best interest.</p> <p>NHP follows all state and federal guidelines for extending time frames for resolution of grievances and appeals (both expedited and standard appeals) by fourteen (14) calendar days.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>As a delegated function, NHP follows Beacon’s 303L_Grievance Policy which outlines that we can extend the time frame for the resolution of a grievance by up to 14 calendar days if the member requests the extension or if there is a need for additional information and that the delay is in the member’s best interest. See 303L_Grievance Policy_NHP page 8. NHP notifies the member within 2 business days when there has been a request for an extension and attempts to contact the member on the phone. NHP sends out a letter to the member to notify them of the need for additional time and explains why it is in their best interest. See Complaint Delay Letter_NHP, entire document.</p> <p>NHP follows Beacon’s 305L_Appeal Policy_NHP which outlines the protocols followed when either a member requests an extension, or when the RAE believes it would be in the member’s best interest to have additional time to make a decision. We send the member written notification when the time frame is extended. The policy states that we will include the reason for the extension, the date by which a final determination will be made, and the notification of member’s rights to file a grievance if the member disagrees with the extension. See 305L_Appeal Policy_NHP, pages 2, 7, and 9. The Member Engagement Specialist will send notification to the member within two (2) business days once it is ascertained that additional days are needed. See Appeal Extension Letter_NHP, entire document. In the body of the letter, we document why it is in the member’s best interest to delay the appeal. Please see Example of Appeal Extension Letter_NHP for content that is embedded in the letter with the reason for filing extension as well as the right to file a grievance if there is a disagreement about the extension.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	Members are made aware of the ability to delay either a grievance or appeal by up to fourteen (14) calendar days in the Appeal Guide and Complaint Guide located on our website, www.northeasthealthpartners.org . See Complaint Guide_NHP, page 3. See Appeal Guide_NHP, pages 3-5. Members are also alerted about this ability to delay a grievance or appeal decision in the Notice Of Adverse Benefit Determination Letter_NHP on page 5, 6.	
<p>25. If the Contractor extends the time frames, it must—for any extension not requested by the member:</p> <ul style="list-style-type: none"> • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires. <p style="text-align: right;"><i>42 CFR 438.408(c)(2)</i></p> <p>Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 305L_Appeal Policy_NHP, pages 2 F 1b, 10 #5bi 2. 303L_Grievance Policy_NHP page 8 #15b-c 3. Complaint Guide_NHP, page 3 4. Appeal Guide_NHP, pages 3, 5 *Misc 5. Complaint Delay Letter_NHP, entire document 6. Appeal Extension Letter_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners makes reasonable efforts to verbally notify the member promptly if there an extension in making a decision about an appeal or a grievance when it is not requested by the member. NHP sends a letter within two (2) calendar days of when the decision was to be made and alerts the member in this letter that they can file a grievance about the delay. NHP will attempt to expeditiously resolve the appeal as the member’s health condition requires and no longer the expiration of the extension date.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>As a delegated function, NHP follows Beacon’s 303L_Grievance Policy which outlines the procedures for when a resolution timeframe needs to be extended. This includes verbally notifying the member and sending a letter with information on how to file a grievance if the member does not agree with the extension. See 303L_ Grievance Policy, page 8.</p> <p>NHP follows Beacon’s 305L_Appeal Policy_NHP which outlines the procedures for when a resolution timeframe needs to be extended for an appeal. This includes verbally notifying the member, sending a letter with information on the reason for the delay and how to file a grievance if the member does not agree with the extension, and our intent to make a decision as expeditiously as the member’s health requires. See 305L_Appeal Policy_NHP, pages 2, 10.</p> <p>NHP notifies the member within 2 business days when there has been a request for an extension for an appeal or grievance and attempts to contact the member on the phone to communicate this information. NHP sends out letters to the member to notify them of the delay. See Complaint Delay Letter_NHP and Appeal Extension Letter_NHP.</p> <p>NHP developed a Complaint Guide and an Appeal Guide to educate members on the reason there may be a delay in resolving their complaint or appeal. The guides state that NHP may extend the decision date by up to fourteen (14) calendar days. These guides can be found on NHP’s website, www.northeasthealthpartners.org. See Complaint Guide_NHP, page 3 and Appeal Guide_NHP, pages 3 and 5.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>26. The written notice of appeal resolution must include:</p> <ul style="list-style-type: none"> The results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member: <ul style="list-style-type: none"> The right to request a State fair hearing, and how to do so. The right to request that benefits/services continue* while the hearing is pending, and how to make the request. That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor’s adverse benefit determination. <p><i>*Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.</i></p> <p style="text-align: right;"><i>42 CFR 438.408(e)</i></p> <p>Contract: Exhibit B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, page 11 G 1, 11 G 3a-d Appeal Guide_NHP, pages 5-6 *Misc State Fair Hearing Guide_NHP, entire document Appeal Decision Letter_NHP, pages 3-4 Appeal Decision Letter Example_NHP, entire document <p>Narrative:</p> <p>Northeast Health Partners documents in the appeal decision letter the results of the resolution process and the date it was completed. The appeal decision letter includes members’ right and procedures to request a State Fair Hearing if an appeal decision is not resolved wholly in favor of the member. The appeal decision letter outlines that members can request that previously authorized benefits continue while the hearing is pending, how to make this request and that the member may be held liable for the cost of these services if the hearing decision upholds NHPs’ adverse benefit determination. See Appeal Decision Letter_NHP, pages 3-4.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP. The policy outlines that the written notice will include the date the appeal decision was made, how members can request a State Fair Hearing, how members can request for services to continue throughout the hearing, and the member’s responsibility for payment if the State Fair Hearing is not in the member’s favor. See 305L_Appeal Policy_NHP, page 11.</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>NHP developed an Appeal Guide to educate members on their rights when an appeal decision is not wholly in the member’s favor. The guide states that members can file a State Fair Hearing and lists the ways that NHP can assist the member in filing a State Fair Hearing. The guide also informs members that they can request for their previously authorized services to continue during the hearing process and the member’s financial responsibility if the hearing is not in their favor. The Appeal Decision Letter includes a State Fair Hearing Guide so that members know what to expect during a State Fair Hearing. See Appeal Guide_NHP, pages 5 and 6.</p> <p>NHP also developed the State Fair Hearing guide which states that a member can request a State Fair Hearing when their appeal was not in the member’s favor on page 1. The guide outlines that members can request for the previously authorized services to continue during the hearing, what a member can expect from NHP and the members’ financial responsibility for the services they received during the course of the hearing if the hearing results are not in their favor. See State Fair Hearing Guide_NHP, pages 2-3.</p>	
<p>Findings:</p> <p>While internal policies and procedures accurately defined the content of the appeal resolution letter, the content of actual appeal resolution letters and the <i>SFH Guide</i> insert did not clearly outline procedures for how to request continued benefits during an SFH as follows:</p> <ul style="list-style-type: none">• The appeal resolution letter informs the member of the right to request continued benefits during the SFH if continued benefits are requested in 10 days; however, the information did not clarify that the member must be the one to request continued benefits—i.e., cannot be the provider—or inform the member that continued benefits must be requested through NHP. In addition, the information did not explain that a request for continued benefits during an SFH applies only if the member had also continued benefits during the appeal.• The <i>SFH Guide</i> inserted into the appeal resolution letter informs the member that, to continue services during the SFH, the member must request that services continue, but does not tell the member how to make the request—i.e., to make the request to NHP within 10 days of the adverse appeal resolution letter.		



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> The sample overturned appeal decision letter informed the member that he or she may request an SFH. A request for an SFH applies only to “appeals not resolved in favor of the member.” 		
Required Actions: NHP must clarify information in its appeal resolution letter and <i>SFH Guide</i> regarding how the member may request continued benefits during an SFH. NHP must also remove information regarding the member’s right to request an SFH from its overturned appeal decision letters.		
<p>27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.</p> <ul style="list-style-type: none"> If the Contractor does not adhere to the notice and timing requirements regarding a member’s appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. <p style="text-align: right;"><i>42 CFR 438.408(f)(1–2)</i></p> <p>Contract: Exhibit B2—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, pages 1 IC, 11 G #4b Appeal Guide_NHP, page 6 *Misc State Fair Hearing Guide_NHP, page 1 Appeal Decision Letter_NHP, pages 3,4 NOABD_NHP, page 6 *Misc Provider Handbook2019_NHP *Misc, page 16 <p>Narrative:</p> <p>Northeast Health Partners upholds the member’s right to request a State Fair Hearing within 120 calendar days upon receipt of an adverse appeal determination or if NHP fails to meet the notice and timing requirements. If NHP does not meet the requirements, the appeal rights will be determined to be exhausted.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which states that members have 120 calendar days from the date on the Adverse Appeal Decision letter to request a State Fair Hearing. The policy outlines that the appeal process will have been considered exhausted if the regional organization does not follow the notice and timing requirements. If the appeal process has been exhausted, members call file a State Fair Hearing. See 305L_Appeal Policy_NHP, pages 1 and 11.</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>NHP’s Member Engagement Specialist sends the member an appeal decision letter which outlines the timeframe that a member can request a State Fair Hearing in the event of an adverse determination. The Appeal Decision letter records the exact date that the member must request a State Fair Hearing by – which is 120 calendar days from the date of the Appeal Decision Letter. See Appeal Decision Letter_NHP, pages 3-4.</p> <p>NHP developed an appeal guide which outlines that a member’s appeal benefits will have been considered exhausted if NHP does not adhere to the timelines and processes and that members can file a state fair hearing if this happens. See Appeal Guide_NHP, page 6.</p> <p>NHP developed a State Fair Hearing Guide which indicates the timeframe that members have to request a state fair hearing. The guide also explains that if NHP did not follow the appeal time frames, that the member can request a state fair hearing before filing an appeal. See State Fair Hearing Guide_NHP, page 1.</p> <p>NHP sends members a notice of adverse benefit determination letter when there is a denial in behavioral health services. The letter explains that members have 120 days to request a state fair hearing if the decision about their appeal is not in the member’s favor. The letter also explains that if NHP does not meet the appeal deadlines, that members may request a state fair hearing without waiting for us to decide their appeal. See NOABD_NHP, page 6.</p> <p>Beacon developed and maintains the Provider Handbook2019_NHP which educates providers on the 120-day timeframe for members to file a State Fair Hearing in the event of an adverse appeal decision. See Provider Handbook2019_NHP, page 16.</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
Findings: NHP's <i>Appeal Policy</i> and member communications regarding appeal processes accurately defined the 120-day time frame for requesting an SFH. However, the <i>SFH Guide</i> also inaccurately stated, "If NHP does not follow the appeal time frames, you may request an SFH <i>before you file an appeal</i> . (The member must first file an appeal with NHP and, thereafter, if NHP does not meet the appeal time frames, the member may request a SFH.)"		
Required Actions: NHP must correct its <i>SFH Guide</i> to remove the phrase "before you file an appeal" from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames.		
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. <i>42 CFR 438.408(f)(3)</i> Contract: Exhibit B2—8.7.15.3	Evidence: 1. 305L_Appeal Policy_NHP, page 7, #3f 2. State Fair Hearing Guide_NHP, page 2 3. Appeal Decision Letter_NHP, page 4 Narrative: Northeast Health Partners has procedures in place to include NHP, the member, the member's representative, or the representative of a deceased member's estate at a State Fair Hearing. As a delegated function, NHP follows Beacon's 305L Appeal Policy which outlines the parties that need to be included in a State Fair Hearing which include the member and their representative or the representative of a deceased member's estate. See 305L_Appeal Policy_NHP, page 7. NHP developed a State Fair Hearing Guide which outlines the parties that can participate in the State Fair Hearing which includes a representative from NHP, the member or their designated representative or representative from the member's deceased estate.	NHP <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	The Member Engagement Specialist sends this guide with the Appeal Decision Letter. See State Fair Hearing Guide_NHP, page 2. See Appeal Decision Letter_NHP, page 4.	
<p>29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if:</p> <ul style="list-style-type: none"> The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: <ul style="list-style-type: none"> Within 10 days of the Contractor mailing the notice of adverse benefit determination. The intended effective date of the proposed adverse benefit determination. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. The services were ordered by an authorized provider. The original period covered by the original authorization has not expired. The member requests an appeal in accordance with required time frames. 	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, page 8 C a-f Provider Handbook2019_NHP, pages 18 *Misc Appeal Guide_NHP, pages 5 and 6 *Misc State Fair Hearing Guide_NHP, pages 2-3 NOABD_NHP, page 7 *Misc <p>Narrative:</p> <p>Northeast Health Partners provides for continuation of benefits/services during an appeal or state fair hearing which may be pending if a member requests for services to be continued within ten (10) days of receiving the Adverse Benefit Determination or the intended effective date of the Adverse Benefit Determination. The services need to be ordered by an authorized provider. For services that were previously authorized, the authorization end date has not expired. And, the member needs to request an appeal within the required timeframes.</p> <p>As a delegated function, NHP follows Beacon’s 305L Appeal Policy which outlines the requirements for members to request a continuation in their services. The policy states the requirements NHP follows which allow continuation of benefits only under certain circumstances. The member has to: 1) request continuation of service in a timely fashion -- within 10 days of NHP mailing the adverse benefit determination or the intended effective date of the</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p><i>* This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)</i></p> <p style="text-align: right;"><i>42 CFR 438.420(a) and (b)</i></p> <p>Contract: Exhibit B2—8.7.13.1 10 CCR 2505-10 8.209.4.T</p>	<p>proposed adverse benefit determination; 2) the appeal is regarding a termination, suspension, or reduction of a previously authorized course of treatment; 3) the services were ordered by an authorized provider; 4) the original period covered by the original authorization has not expired; 5) and the member requests an appeal timely. The policy also states that a provider cannot request continuation of benefits on behalf of a member. See 305L_Appeal Policy_NHP, page 8 C a-f.</p> <p>NHP sends members a Notice of Adverse Benefit Determination Letter when there is a denied behavioral health service. The letter outlines the procedures members need to follow if they would like to request for continuation of services during the appeal. See NOABD_NHP, page 7.</p> <p>NHP developed an Appeal Guide and a State Fair Hearing Guide which outlines all of these requirements for continuation of benefits to continue. These guides are mailed with the Appeal Receipt Letter or the Appeal Decision Letter and are also located on NHPs' website. See Appeal Guide_NHP, pages 5, 6 and State Fair Hearing Guide_NHP, pages 2-3.</p> <p>Beacon has developed and maintains the Provider Handbook2019_NHP which documents the requirements for members requesting a continuation of services during an appeal or State Fair Hearing. The handbook notes that a provider cannot request a continuation of services on a member's behalf. See Provider Handbook2019_NHP, pages 18.</p>	
<p>Findings: The <i>Appeal Policy</i> and member communications accurately addressed the criteria regarding continuing benefits during an appeal. However, the <i>SFH Guide</i> for members similarly applied each of these criteria to continuing benefits during an SFH, which are not applicable in their entirety. While the language of the written federal regulation does not clearly differentiate between criteria applicable to appeals vs. criteria applicable to</p>		



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>SFH, HSAG verbally clarified during on-site interviews the interpretation of the applicability of these criteria for continuing benefits during a SFH: Bullet #1—“timely filing for continuation of benefits” means the member must have continued benefits during the appeal and must again request continued benefits during an SFH within 10 days of receiving notice of an adverse <i>appeal resolution</i>. The intended effective date of the adverse benefit determination no longer applies. Bullet #4—“the original period covered by the original authorization has not expired” does not apply to continuing benefits during an SFH. Bullet #5—the member must request an “SFH” in accordance with required time frames (120 days from the adverse appeal decision). HSAG found that NHP’s <i>SFH Guide</i> included the following inaccuracies:</p> <ul style="list-style-type: none"> • “The time period for the authorized service must not be over yet” applies to continuing benefits during an appeal, but not to SFH. • In two places in the <i>SFH Guide</i>, it accurately stated the member must request continued benefits during an SFH within 10 days of an adverse appeal decision, but also inaccurately stated the member must request an SFH within 10 days. (Per 42 CFR 438.408[f], the member may request an SFH within 120 days from the adverse appeal decision). <p>In addition, during appeal record reviews, HSAG found the appeal resolution letter included information pertaining to continued benefits during the SFH, which was not applicable in the individual member’s situation. Due to inaccuracies in the SFH information provided to members, HSAG scored four of six eligible appeal record reviews as <i>Not Met</i> for “resolution letter includes required content.”</p> <p>Required Actions: NHP must clarify information in its <i>SFH Guide</i> to accurately represent the requirements for requesting continued benefits during an SFH. NHP must also ensure that information pertaining to continuation of benefits during an SFH is not included in letters where continuation of benefits does not apply to the member’s situation.</p>		
<p>30. If, at the member’s request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs:</p> <ul style="list-style-type: none"> • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends 	<p>Evidence:</p> <ol style="list-style-type: none"> 1. 305L_Appeal Policy_NHP, pages 8 D 2. State Fair Hearing Guide_NHP, pages 3 3. Provider Handbook2019_NHP, pages 18 *Misc <p>Narrative:</p> <p>Northeast Health Partners will continue or reinstate benefits during the appeal or state fair hearing unless certain conditions occur. The conditions are that the member withdraws the appeal or State Fair Hearing request, the member fails to request a State Fair Hearing</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>the notice of an adverse resolution to the member's appeal.</p> <ul style="list-style-type: none">• A State fair hearing officer issues a hearing decision adverse to the member. <p>Contract: Exhibit B2—8.7.13.2 10 CCR 2505-10 8.209.4.U</p> <p>42 CFR 438.420(c)</p>	<p>and continuation of benefits within ten (10) calendar days of receipt of the Notice of Adverse Resolution, or a State Fair Hearing Officer issues a hearing decision which is adverse to the member.</p> <p>As a delegated function, NHP follows Beacon's 305L_Appeals Policy which states the requested service will continue unless the member withdraws the appeal, ten (10) calendar days pass after the RAE mails the notice providing the resolution of the appeal upholding the original RAE termination, suspension, or reduction of services, unless the member, within a ten (10) calendar day time frame makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached; or the State Fair Hearing Office issues a hearing decision adverse to the member. See 305L_Appeal Policy_NHP, page 8.</p> <p>NHP developed a State Fair Hearing Guide which outlines that NHP will continue or reinstate benefits unless certain conditions exist. See State Fair Hearing Guide_NHP, page 3.</p> <p>Beacon has developed and maintains a Provider Handbook2019_NHP which outlines that the regional organization will continue or reinstate member benefits unless certain conditions occur. See Provider Handbook2019_NHP, pages 18.</p>	
<p>Findings:</p> <p>NHP's <i>Appeal Policy</i> accurately stated the criteria related to how long benefits will continue during an appeal. However, the <i>SFH Guide</i> for members similarly applied each of these criteria to how long benefits will continue during an SFH, which are not applicable in their entirety. HSAG provided on-site guidance that criteria Bullet #2 applies only to appeals, not to an SFH. If a member requests continued benefits during an SFH, benefits will continue until either: the member withdraws the request for an SFH or an SFH officer issues a hearing decision adverse to the member.</p>		



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
Required Actions: NHP must revise its <i>SFH Guide</i> to remove the clause “you do not request an SFH and continued services within 10 days of an appeal decision not in your favor” from the description of how long benefits will continue during an SFH.		
<p>31. Member responsibility for continued services:</p> <ul style="list-style-type: none">If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor’s adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. <p style="text-align: right;"><i>42 CFR 438.420(d)</i></p> <p>Contract: Exhibit B2—8.7.13.3 10 CCR 2505-10 8.209.4.V</p>	<p>Evidence:</p> <ol style="list-style-type: none">305L_Appeal Policy_NHP, page 8 D 1Appeal Guide_NHP, page 6 *MiscState Fair Hearing Guide_NHP, page 3Provider Handbook2019_NHP, page 18 *Misc <p>Narrative:</p> <p>Northeast Health Partners may recover the cost of services provided to the member while an appeal or State Fair Hearing was pending if the decision upholds the adverse benefit determination and the reason that the services were provided were based on the requirements in this section.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which outlines that costs of services can be recovered by the RAE when services were provided to the member during an appeal or State Fair Hearing and the appeal determination upholds the original decision to deny services to the extent that the services were furnished solely based on the requirements of this section. See 305L_Appeal Policy_NHP, page 8.</p> <p>NHP developed an Appeal Guide and a State Fair Hearing Guide which outlines that members may be financially responsible to repay for any services that were provided during the appeal if the appeal decision was upheld by an external entity. See Appeal Guide_NHP, page 6 and State Fair Hearing Guide_NHP page 3.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



**Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for Northeast Health Partners (Region 2)**

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	NHP developed and maintains the Provider Handbook2019_NHP which states that if the RAE’s decision on a member’s appeal is adverse to the member, the RAE may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements of this section. See Provider Handbook2019_NHP, page 18.	
<p>32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member’s health condition requires but no later than 72 hours from the date it receives notice reversing the determination.</p> <p style="text-align: right;"><i>42 CFR 438.424(a)</i></p> <p>Contract: Exhibit B2—8.7.13.4 10 CCR 2505-10 8.209.4.W</p>	<p>Evidence:</p> <ol style="list-style-type: none">305L_Appeal Policy_NHP, pages 8-9 #2aProvider Handbook2019_NHP, page 18 *MiscEvidence of Authorization After Appeal_NHP, entire documentEvidence of Overturned Appeal Decision Letter_NHP, Entire Document <p>Narrative:</p> <p>Northeast Health Partners will authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires but no later than 72 hours from the date NHP receives the notice reversing the adverse determination.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which outlines that the RAE will authorize or provide the disputed services promptly or as expeditiously as possible but no later than 72 hours from the date that we receive the notice reversing the adverse determination. See 305L_Appeal Policy_NHP, pages 8-9.</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>NHP developed and maintains the Provider Handbook which outlines that the regional organization will authorize or provide the disputed services promptly or as expeditiously as possible but no later than 72 hours from the date that we receive the notice reversing the adverse determination. See Provider Handbook2019_NHP, page 18.</p> <p>NHP has submitted evidence of authorizing services which had been previously denied. A guardian had requested RTC services for her daughter which were denied. The peer reviewer overturned this decision. See Evidence of Overturned Appeal Decision Letter_NHP, entire document. Beacon’s care manager updated the authorization within 72 hours to reflect that these services would be covered. See Evidence of Authorization After Appeal_NHP, entire document.</p>	
<p>33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.</p> <p style="text-align: right;"><i>42 CFR 438.424(b)</i></p> <p>Contract: Exhibit B2—8.7.13.5 10 CCR 2505-10 8.209.4.X</p>	<p>Evidence:</p> <ol style="list-style-type: none"> 305L_Appeal Policy_NHP, page 9 b Provider Handbook2019_NHP, page 19 *Misc Evidence of Payment_NHP, entire document Appeal Job Aid_NHP, page 13 <p>Narrative:</p> <p>Northeast Health Partners will pay for any disputed services a member receives while the appeal was pending if NHP or the State Fair Hearing reverses the decision to deny authorization of services.</p> <p>As a delegated function, NHP follows Beacon’s 305L Appeal Policy which states that the regional organization will authorize and pay for disputed services while the appeal was pending if the</p>	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>regional organization or the State Fair Hearing officer reverses a decision to deny authorization of services. See 305L_Appeal Policy_NHP, page 9.</p> <p>The Member Engagement Specialist follows the Appeal Job Aid_NHP which outlines procedures to be followed when an appeal decision is reversed. The Job Aid states that when we receive notification of a reversal of a decision, the Member Engagement Specialist will notify the clinical team to update the authorization and send to claims so that Beacon can pay the authorization. See Appeal Job Aid_NHP, page 13.</p> <p>Beacon has developed and maintains the Provider Handbook2019_NHP which states that the regional organization will pay for any disputed service that was provided while the appeal was pending and the decision was reversed by either the regional organization or the State Fair Hearing officer. See Provider Handbook2019_NHP, page 19.</p> <p>NHP has included an email chain reflecting that payment for services was made once an appeal had been overturned. See Evidence of Payment_NHP, entire document.</p>	
<p>34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS.</p> <ul style="list-style-type: none"> The record of each grievance and appeal must contain, at a minimum, all of the following information: 	<p>Evidence:</p> <ol style="list-style-type: none"> Feedback Database_NHP, entire document 303L_Grievance Policy_NHP page 9 C A1a-j, 9 C5 305L_Appeal Policy_NHP, pages 12-13 1a-f Grievance and Appeal Excel Report_NHP, entire document. 	<p>NHP</p> <p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. <p style="text-align: right;"><i>42 CFR 438.416</i></p> <p>Contract: Exhibit B2—8.9.1–8.9.1.6 10 CCR 2505-10 8.209.3.C</p>	<p>Narrative:</p> <p>NHP has delegated the maintenance of records related to grievances and appeals to Beacon Health Options. Beacon maintains records of all grievances and appeals in an accurate manner which is accessible to the State and available upon request to CMS. Beacon is responsible to submit a quarterly report to HCPF with a general description of the reason for each grievance or appeal, the date the appeal/grievance was received and resolved, the name of the person for whom the grievance/appeal was filed, the date of each review if applicable, and the resolution.</p> <p>As a delegated function, NHP follows Beacon’s 305L_Appeal Policy_NHP which has a section entitled Monitoring and Reporting by the Member Engagement Specialist. Each appeal is logged upon receipt and assigned expeditiously to an appropriate reviewer with notification to the reviewer of the timeline for a resolution. All required information is recorded and documented in Beacon’s secure file storage system. See 305L_Appeal Policy_NHP, pages 12-13.</p> <p>NHP follows Beacon’s 303L_Grievance Policy which outlines the necessary information that the Member Engagement Specialist or Advocate need to enter into the feedback database which includes the date the grievance is received, member’s name, description of grievance, date of and resolution at each level of review for the grievance (if applicable) and the date of grievance resolution. The policy states that the RAE will submit a quarterly report to the state with all of this information. See 303L_Grievance Policy_NHP page 9. Beacon’s Member Engagement Specialist is responsible to</p>	



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>review the feedback database on a monthly basis to ensure fidelity to the collection of data. See Feedback Database_NHP, entire document.</p> <p>NHP submits the Grievance and Appeal Report on a quarterly basis to HCPF. The report includes an excel spreadsheet that separates out appeals and grievances. HCPF requires that we document the date the grievance or appeal is received, member's name, the description of grievance or appeal, date of and resolution at each level of review for the grievance/appeal (if applicable) and the date of grievance/appeal resolution. See Grievance and Appeal Excel Report_NHP, entire document.</p>	
<p>35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes:</p> <ul style="list-style-type: none"> • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: 	<p>Evidence:</p> <ol style="list-style-type: none"> 1. Provider Contract_NHP, pages 6, 9, 18, 27 2. Provider Handbook2019_NHP, pages 15 – 19 *Misc <p>Narrative:</p> <p>Northeast Health Partners has delegated the provider network responsibilities to Beacon Health Options. Providers must sign a contract when they enter the network which serves Medicaid members. When providers sign the contract, they attest that they will follow the Provider Handbook2019_NHP which has all of the information about the grievance, appeal, and State Fair Hearing processes and systems. See Provider Contract, pages 6, 9, 18, 27. The information in the handbook includes the member's right to file a grievance or appeal, the requirements and timeframes to file grievances and appeals, the member's right to a State Fair Hearing when NHP makes a decision on an appeal which is adverse to the member, availability to help members with the filing process, the</p>	<p>NHP</p> <p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Standard VI—Grievances and Appeals		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none">Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. <p style="text-align: right;"><i>42 CFR 438.414</i> <i>42 CFR 438.10(g)(xi)</i></p> <p>Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B</p>	member’s right to request continuation of services when certain requirements are met and that members may be required to pay for the cost of the service if the State Fair Hearing is adverse to the member. See Provider Handbook2019_NHP, pages 15-19.	
Findings: NHP’s provider handbook (as referenced in the provider contract) described the detailed processes related to processing grievances and appeals. However, the provider handbook included inaccuracies in the circumstances and standards related to requesting continued benefits during an SFH (i.e., mimics the inaccuracies noted in element #29). In addition, HSAG noted that the provider handbook did not indicate <i>how</i> a member must request continued benefits (e.g., from NHP), nor did it specify that a provider cannot request continued benefits on behalf of a member. HSAG recommends that NHP consider adding these clarifications to the provider handbook.		
Required Actions: NHP must revise the grievance and appeal information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH, as outlined in findings related to 42 CFR 438.420(a-b)—element #29 in this tool.		



Appendix A. Colorado Department of Health Care Policy and Financing FY 2019–2020 Compliance Monitoring Tool for Northeast Health Partners (Region 2)

Results for Standard VI—Grievances and Appeals									
Total	Met	=	27	X	1.00	=	27		
	Partially Met	=	8	X	.00	=	0		
	Not Met	=	0	X	.00	=	0		
	Not Applicable	=	0	X	NA	=	NA		
Total Applicable		=	35		Total Score	=	27		
Total Score ÷ Total Applicable						=	77%		



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Northeast Health Partners (Region 2)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 26, 2020
Reviewer:	Erika Bowman, BA, CPC—HSAG
Participating Plan Staff Member(s):	Dr. Steve Coen and Tiffany Jenkins

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	1/9/19	2/1/19	4/1/19	4/10/19	5/28/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	S	S	S
Date notice of adverse benefit determination (NABD) sent	1/10/19	2/1/19	4/5/19	4/11/19	5/30/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	1	0	4	1	2
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	NM	NM	M
Total Applicable Elements	6	6	6	6	6
Total Met Elements	5	5	5	5	6
Score (Number Met / Number Applicable) = %	83%	83%	83%	83%	100%

* = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, NM = Not Met, NA = Not Applicable, Cal = Calendar, Y = Yes, N = No (Yes and No = not scored—informational only)

**** = Redacted Member ID



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Northeast Health Partners (Region 2)

Comments:

File 1: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria,” “less intensive,” and “less restrictive setting” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 2: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria” and “less restrictive setting” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 3: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria,” “less intensive,” and “lower level of care” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 4: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria,” “less intensive,” and “lower level of care” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.



**Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Northeast Health Partners (Region 2)**

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	7/23/19	8/9/19	9/27/19	11/9/19	12/4/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	S	S	S
Date notice of adverse benefit determination (NABD) sent	7/23/19	8/9/19	9/28/19	11/12/19	12/6/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	0	0	1	3	2
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (N or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	NM	NM	NM	M
Total Applicable Elements	6	6	6	6	6
Total Met Elements	6	5	5	5	6
Score (Number Met / Number Applicable) = %	100%	83%	83%	83%	100%

* = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Northeast Health Partners (Region 2)

Comments:

File 7: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria,” “less intensive,” and “less restrictive setting” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 8: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria” and “less restrictive setting” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 9: This was a new service request. NHP’s NOABD incorporated language such as “exclusionary criteria” and “less restrictive setting” to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

Total Record Review Score*	Total Applicable Elements: 60	Total Met Elements: 53	Total Score: 88%
---------------------------------------	--	-----------------------------------	-----------------------------

* Only requirements with an “*” in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Grievance Record Review Tool for Northeast Health Partners (Region 2)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 26, 2020
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member(s):	Lynne Bakalyan, Dawn Claycomb

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	1/10/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	1/12/19	1w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
Comments: This was a delegate-processed grievance. The grievance was not clinical. The resolution letter used language such as “reiterated” and “regional organization,” which would not be easily understood by a member with limited reading ability.										
2	****	1/28/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	1/29/19	1w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: This grievance was not clinical.										
3	****	2/27/19	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	2/27/19	0w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: The grievance was resolved the same day it was received. No acknowledgement letter was required. The grievance was not clinical.										
4	****	2/28/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	3/11/19	7w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: The grievance was acknowledged on 3/1/19. The grievance was not clinical.										
5	****	3/13/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	3/29/19	12w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: The grievance was acknowledged on 3/14/19. The complaint was about care received from the provider—the member was unhappy that her opiate medication was changed. NHP explored the grievance with the medical director of the facility. NHP noted that this was in the time period following the directive from the Department to decrease opioid medications and that related member grievances surged during that time.										
6	****	5/22/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	6/10/19	13w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: This was a delegate-processed grievance. The grievance was regarding clinical care and was explored with the medical director at the facility.										
7	****	6/12/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	6/15/19	2w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: This was a delegate-processed grievance. The grievance was not clinical.										
8	****	9/29/19	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	9/29/19	0w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: The grievance was resolved the same day it was received. No acknowledgement letter was required. The grievance was not clinical.										
9	****	10/10/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	10/23/19	9w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: The grievance was not clinical.										



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Grievance Record Review Tool for Northeast Health Partners (Region 2)

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
10	****	12/12/19	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	12/13/19	1w	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>
Comments: The grievance was resolved the day following receipt. The resolution letter served as the acknowledgement. The member was confused by communication by the dental office that the prior authorization had expired and erroneously informed the member that he/she needed to resubmit a new prior authorization request (PAR). NHP resolved with dental provider that the PAR is the provider's responsibility and informed the member of the same.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			7			10	10	2	10	10
Column Subtotal of Compliant (Met) Elements			7			10	10	2	10	9
Percent Compliant (Divide Met by Applicable)			100%			100%	100%	100%	100%	90%

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	49
Total Compliant (Met) Elements	48
Total Percent Compliant	98%

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Appeals Record Review Tool for Northeast Health Partners (Region 2)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 26, 2020
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member(s):	Lynne Bakalyan, Dawn Claycomb

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 3/1/19 for services denied 10/9/18. The appeal was not processed by NHP as it included no DCR form and was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
2	****	3/27/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	3/29/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: None.											
3	****	5/3/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	5/22/19	M <input type="checkbox"/> N <input checked="" type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: The original written appeal was received on 5/3/19 but included no DCR form for the mother of the child to appeal on behalf of the member (beyond legal age). The DCR form was received on 5/5/19, and the appeal was initiated. Acknowledgement was sent on 5/6/19. The time frame was not extended, and the resolution letter was not within the required time frame. The appeal resolution letter included information pertaining to continued benefits during the SFH, which was not applicable. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											
4	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider at exactly the 60-day time frame. However, the appeal included no DCR form. The appeal was not processed by NHP as it included no DCR form. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
5	****	7/1/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	7/5/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: The member was initially authorized for one day of inpatient stay and then denied for any days forward. The appeal decision upheld the original denial decision. The appeal resolution letter included information pertaining to continued benefits during the SFH, which was not applicable. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											
6	****	8/26/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	9/6/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: The NOABD was for the last two days of an inpatient stay. The appeal decision upheld the original denial decision. The appeal resolution letter included information pertaining to continued benefits during the SFH, which was not applicable. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Appeals Record Review Tool for Northeast Health Partners (Region 2)

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
7	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider and included no DCR form. The appeal was not processed by NHP as it included no DCR form. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
8	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 10/1/19 for services denied 7/11/19. The appeal was not processed by NHP as it included no DCR form and was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
9	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 10/21/19 for services denied 8/19/19. The appeal was not processed by NHP as it was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
10	****	12/4/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	12/17/19	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>
Comments: The appeal resolution letter included information pertaining to continued benefits during the SFH, which was not applicable. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter. The letter also included clinical acronyms regarding alternative therapies—e.g., “MST”—that would not be easy for the member to understand.											
OS1	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider. The appeal was not processed by NHP as it included no DCR form and was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
OS2	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider. The appeal was not processed by NHP as it included no DCR form. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
OS3	****	5/29/19	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	6/3/19	M <input type="checkbox"/> N <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's DCR for an NOABD on 5/24/19 denying continued inpatient stay. The appeal was expedited and required no acknowledge letter. NHP notified the DCR verbally on 5/31/19 that appeal upheld the original adverse benefit determination. However, the appeal resolution letter was not sent within the 72-hour time frame. (Notes in the appeal file indicated the letter was sent on 5/31/19, and staff members speculated that the date on the letter may have been a typo.)											



Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Appeals Record Review Tool for Northeast Health Partners (Region 2)

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
OS4	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This was a verbal appeal on 5/9/19 (for a denial on 5/8/19) in which the original denial decision was reversed the day it was appealed. The appeal was withdrawn by the member. This record was omitted from the sample.											
OS5	****	OMIT	M <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/>
Comments: This appeal was filed by the member's inpatient provider. The appeal was not processed by NHP as it included no DCR form and was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through NHP's provider dispute process. This record was omitted from the sample.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			5	6	6				6	6	6
Column Subtotal of Compliant (Met) Elements			5	6	6				4	2	5
Percent Compliant (Divide Met by Applicable)			100%	100%	100%				67%	33%	83%

Key: M = Met; N = Not Met
 N/A = Not Applicable
 Yes; No = Not scored—information only

Total Applicable Elements	35
Total Compliant (Met) Elements	28
Total Percent Compliant	80%

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **NHP**.

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

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Erika Bowman	Project Manager
Sarah Lambie	Project Manager II
NHP Participants	Title
Alma Mejorado	Director of Provider Relations, Beacon Health Options
Alyssa Rose	Assistant Vice President of Operations, Beacon Health Options
Catherine Morrissey	Director, Quality Improvement, Northeast Health Partners
Christine Andersen	Director of Integration, Beacon Health Options
D’Anne Goldstein	Administrative Assistant, Beacon Health Options
Dawn Claycomb	Community Outreach Specialist, Beacon Health Options
Dr. Lisa Clements	Senior Director of Integration, Beacon Health Options
Dr. Steve Coen, PhD	Peer Advisor, Beacon Health Options
Erica Arnold-Miller	Director of Quality Management, Beacon Health Options
Jennifer Hale-Coulson	Director of Care Coordination, Beacon Health Options
Jeremy White	Quality Manager, Beacon Health Options
Johanna Martinson	Northeast Health Partners/North Colorado Health Alliance
Kat Fitzgerald	Quality Management Specialist, Beacon Health Options
Kari Snelson	Executive Director, Northeast Health Partners
Lynne Bakalyan	Director of Member Services, Beacon Health Options
Mandi Strickland	Director, Operations, Northeast Health Partners
Tami Arnold	Community Liaison, Northeast Health Partners
Tiffany Jenkins	Manager of Clinical Services, Beacon Health Options
Tina McCrory	Chief Operations Officer, Health Colorado, Inc.
Wayne Watkins	Director, Health Information Technology & Data, Northeast Health Partners
Department Observers	Title
Mike Davis	ACC Program Specialist—HCPF
Natasha Brockhaus	ACC Program Administrator—HCPF
Russell Kennedy	Quality & Compliance Specialist—HCPF

Appendix D. Corrective Action Plan Template for FY 2019–2020

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
	<p>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.</p> <p>For each element receiving a score of <i>Partially Met</i> or <i>Not Met</i>, 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.</p>
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
	<p>Following review of the CAP, the Department and HSAG will:</p> <ul style="list-style-type: none"> • 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 <u>also</u> to proceed with implementation.
Step 4	Documentation substantiating implementation
	<p>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.</p>

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

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for NHP

Standard I—Coverage and Authorization of Services		
Requirement	Findings	Required Action
<p>15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs.</p> <p style="text-align: right;">42 CFR 438.404(a) 42 CFR 438.10 (c)</p> <p>Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1</p>	<p>NHP policies and template NOABDs demonstrated that notices to members were written in language easy to understand and informed the member of availability of the letter in other languages and alternative formats. However, HSAG found seven of 10 denial record reviews were <i>Not Met</i> for “correspondence with the member was easy to understand.” NHP’s letter incorporated language such as “exclusionary criteria,” “less intensive,” and “less restrictive” to describe the reason for adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.</p>	<p>NHP must ensure that the NOABD in its entirety is written in language that is easy for a member to understand.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	Findings	Required Action
<p>13. The Contractor ensures timely access by:</p> <ul style="list-style-type: none"> Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. Monitoring network providers regularly to determine compliance. Taking corrective action if there is failure to comply. <p style="text-align: right;"><i>42 CFR 438.206(c)(1)(iv)–(vi)</i></p> <p>Contract: Exhibit B-2—9.5.1.8</p>	<p>NHP implemented a phone survey of a small sample of the behavioral health network to evaluate the availability and timeliness of RAE member appointments. The December 2019 survey results illustrated that all of the standards were met by one of the seven providers surveyed. Of the six providers that did not have access, two providers did not have appointment availability for new members, two providers did not have same day or routine appointment availability for established members, and the remaining three providers were nonresponsive to NHP’s outreach attempts.</p>	<p>NHP must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). NHP must also ensure implementation of CAPs for providers that are not in compliance with the access to care standards.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>12. The Contractor must resolve each grievance and provide notice as expeditiously as the member’s health condition requires, and within 15 working days of when the member files the grievance.</p> <ul style="list-style-type: none"> Notice to the member must be in a format and language that may be easily understood by the member. <p><i>42 CFR 438.408(a) and (b)(1) and (d)(1)</i></p> <p>Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D</p>	<p>NHP’s template complaint resolution letter was written in language easy for the member to understand. However, HSAG found during grievance record reviews that one resolution letter processed by a delegated entity used language such as “reiterated” and “regional organization,” which would not be easily understood by a member with limited reading ability.</p>	<p>NHP must develop a mechanism to ensure that each grievance resolution letter is written in language easy for a Medicaid member to understand.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member’s health condition requires, but not to exceed the following time frames:</p> <ul style="list-style-type: none"> For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. Written notice of appeal resolution must be in a format and language that may be easily understood by the member. <p style="text-align: right;">42 CFR 438.408(b)(2) 42 CFR 438.408(d)(2) 42 CFR 438.10</p> <p>Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1</p>	<p>While NHP’s <i>Appeal Policy</i>, related procedures, and <i>Appeal Guide</i> for members, all required resolution of complaints within 10 working days, HSAG found during on-site appeal record reviews that one case was <i>Not Met</i> for resolution of a standard appeal within the required time frame. In addition, HSAG found that one appeal resolution letter included clinical acronyms regarding alternative therapies—e.g., “MST”—that would not be easy for the member to understand.</p>	<p>NHP must ensure that all standard appeal decisions are made within 10 working days from receipt of the appeal, unless the decision time frame is extended. In addition, NHP must ensure that information in the appeal resolution letter does not include clinical information that would be difficult for a member to understand.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal.</p> <ul style="list-style-type: none"> For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. <p><i>42 CFR 438.408(b)(3) and (d)(2)(ii)</i></p> <p>Contract: Exhibit B2—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L</p>	<p>NHP’s <i>Appeal Policy</i> and related procedures described resolution of expedited appeal decisions with 72 hours of receipt. NHP’s appeal documentation system noted both the time and date of the appeal request and resolution notice. However, during on-site appeal record reviews, HSAG found one expedited appeal in which the member was promptly notified verbally of the decision but NHP failed to send the written resolution to the member within the 72-hour time frame.</p>	<p>NHP must develop a mechanism to ensure that written notice to the member of an expedited appeal decision is sent within 72 hours of receipt of the appeal request.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>26. The written notice of appeal resolution must include:</p> <ul style="list-style-type: none"> The results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member: <ul style="list-style-type: none"> The right to request a State fair hearing, and how to do so. The right to request that benefits/services continue* while the hearing is pending, and how to make the request. That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor’s adverse benefit determination. <p><i>*Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.</i></p> <p>42 CFR 438.408(e)</p> <p>Contract: Exhibit B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M</p>	<p>The content of actual appeal resolution letters and the <i>SFH Guide</i> insert did not clearly outline procedures for how to request continued benefits during an SFH as follows:</p> <ul style="list-style-type: none"> The appeal resolution letter informs the member of the right to request continued benefits during the SFH if continued benefits are requested in 10 days; however, the information did not clarify that the member must be the one to request continued benefits—i.e., cannot be the provider—or inform the member that continued benefits must be requested through NHP. In addition, the information did not explain that a request for continued benefits during an SFH applies only if the member had also continued benefits during the appeal. The <i>SFH Guide</i> inserted into the appeal resolution letter informs the member that, to continue services during the SFH, the member must request that services continue, but does not tell the member how to make the request—i.e., to make the request to NHP within 10 days of the adverse appeal resolution letter. The sample overturned appeal decision letter informed the member that he or she may request an SFH. A request for an 	<p>NHP must clarify information in its appeal resolution letter and <i>SFH Guide</i> regarding how the member may request continued benefits during an SFH. NHP must also remove information regarding the member’s right to request an SFH from its overturned appeal decision letters.</p>

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
	SFH applies only to “appeals not resolved in favor of the member.”	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.</p> <ul style="list-style-type: none"> If the Contractor does not adhere to the notice and timing requirements regarding a member’s appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. <p style="text-align: right;"><i>42 CFR 438.408(f)(1–2)</i></p> <p>Contract: Exhibit B2—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O</p>	<p>NHP’s <i>Appeal Policy</i> and member communications regarding appeal processes accurately defined the 120-day time frame for requesting an SFH. However, the <i>SFH Guide</i> also inaccurately stated, “If NHP does not follow the appeal time frames, you may request an SFH <i>before you file an appeal</i>. (The member must first file an appeal with NHP and, thereafter, if NHP does not meet the appeal time frames, the member may request a SFH.)</p>	<p>NHP must correct its <i>SFH Guide</i> to remove the phrase “before you file an appeal” from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if:</p> <ul style="list-style-type: none"> The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: <ul style="list-style-type: none"> Within 10 days of the Contractor mailing the notice of adverse benefit determination. The intended effective date of the proposed adverse benefit determination. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. The services were ordered by an authorized provider. The original period covered by the original authorization has not expired. The member requests an appeal in accordance with required time frames. <p>* <i>This definition of timely filing only applies for this scenario—i.e., when the</i></p>	<p>The <i>Appeal Policy</i> and member communications accurately addressed the criteria regarding continuing benefits during an appeal. However, the <i>SFH Guide</i> for members similarly applied each of these criteria to continuing benefits during an SFH, which are not applicable in their entirety. HSAG found that NHP’s <i>SFH Guide</i> included the following inaccuracies:</p> <ul style="list-style-type: none"> “The time period for the authorized service must not be over yet” applies to continuing benefits during an appeal, but not to SFH. In two places in the <i>SFH Guide</i>, it accurately stated the member must request continued benefits during an SFH within 10 days of an adverse appeal decision, but also inaccurately stated the member must request an SFH within 10 days. (Per 42 CFR 438.408[f], the member may request an SFH within 120 days from the adverse appeal decision). <p>In addition, during appeal record reviews, HSAG found the appeal resolution letter included information pertaining to continued benefits during the SFH, which was not applicable in the individual member’s situation. Due to inaccuracies in the SFH information provided to members, HSAG</p>	<p>NHP must clarify information in its <i>SFH Guide</i> to accurately represent the requirements for requesting continued benefits during an SFH. NHP must also ensure that information pertaining to continuation of benefits during an SFH is not included in letters where continuation of benefits does not apply to the member’s situation.</p>

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p><i>member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)</i></p> <p><i>42 CFR 438.420(a) and (b)</i></p> <p>Contract: Exhibit B2—8.7.13.1 10 CCR 2505-10 8.209.4.T</p>	<p>scored four of six eligible appeal record reviews as <i>Not Met</i> for “resolution letter includes required content.”</p>	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>30. If, at the member’s request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs:</p> <ul style="list-style-type: none"> • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member’s appeal. • A State fair hearing officer issues a hearing decision adverse to the member. <p style="text-align: right;"><i>42 CFR 438.420(c)</i></p> <p>Contract: Exhibit B2—8.7.13.2 10 CCR 2505-10 8.209.4.U</p>	<p>NHP’s <i>Appeal Policy</i> accurately stated the criteria related to how long benefits will continue during an appeal. However, the <i>SFH Guide</i> for members similarly applied each of these criteria to how long benefits will continue during an SFH, which are not applicable in their entirety. HSAG provided on-site guidance that criteria Bullet #2 applies only to appeals, not to an SFH. If a member requests continued benefits during an SFH, benefits will continue until either: the member withdraws the request for an SFH or an SFH officer issues a hearing decision adverse to the member.</p>	<p>NHP must revise its <i>SFH Guide</i> to remove the clause “you do not request an SFH and continued services within 10 days of an appeal decision not in your favor” from the description of how long benefits will continue during an SFH.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes:</p> <ul style="list-style-type: none"> • The member’s right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: <ul style="list-style-type: none"> – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final 	<p>NHP’s provider handbook (as referenced in the provider contract) described the detailed processes related to processing grievances and appeals. However, the provider handbook included inaccuracies in the circumstances and standards related to requesting continued benefits during an SFH (i.e., mimics the inaccuracies noted in element #29).</p>	<p>NHP must revise the grievance and appeal information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH, as outlined in findings related to 42 CFR 438.420(a-b)—element #29 of the compliance monitoring tool.</p>

Standard VI—Grievances and Appeals		
Requirement	Findings	Required Action
<p>decision is adverse to the member.</p> <p><i>42 CFR 438.414</i> <i>42 CFR 438.10(g)(xi)</i></p> <p>Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B</p>		
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
	<p>Before the site review to assess compliance with federal managed care regulations and contract requirements:</p> <ul style="list-style-type: none"> • 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
	<ul style="list-style-type: none"> • 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 three 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 lists of denials of authorization of services (denials), grievances, and appeals that occurred between January 1, 2019, and December 31, 2019 (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
	<ul style="list-style-type: none"> • 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 denials, grievances, and appeals. • 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
	<ul style="list-style-type: none"> • HSAG used the FY 2019–2020 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 Department
	<ul style="list-style-type: none"> • 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.

Appendix F. Focus Topic Discussion

Overview of FY 2019–2020 Focus Topic Discussion

For the FY 2019–2020 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 *Region-specific Initiatives Related to the Health Neighborhood*. Focus topic interviews were designed to obtain a better understanding of the infrastructure and strategies the RAEs have implemented/are implementing to actively build, support, and monitor Health Neighborhood providers, particularly those serving members with complex health needs (“impactable populations”). 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 FY 2019–2020 RAE Aggregate Report to determine and document statewide trends related to RAE region-specific activities to integrate with and build Health Neighborhoods. This section of the report contains a summary of the focus topic discussion for **NHP**.

Infrastructure and Strategies

NHP is a locally owned joint partnership among two Federally Qualified Health Centers (FQHCs)—Salud Family Health Centers (Salud) and Sunrise Community Health (Sunrise)—and two CMHCs—Centennial Mental Health and North Range Behavioral Health (NRBH). These partners have deep roots providing healthcare services to Region 2 members. **NHP**’s Board of Managers includes representatives of each founding partner. Beacon provides administrative support to **NHP** for many functions and services. Other key partners in Health Neighborhood activities include the North Colorado Health Alliance (NCHA)—**NHP**’s contracted care coordination entity—and Primary Care Medical Providers (PCMPs). **NHP**’s leadership share a strong belief that local communities are in the best position to make changes in the system of care that are cost-effective and improve the health and quality of care for members. Community-based activities are critical to the success of **NHP**’s Health Neighborhood activities. Staff members stated that regional providers and agencies maintain an attitude of partnership and a shared desire to diminish siloing among various healthcare organizations. **NHP**’s criteria for participation in collaborative initiatives include: presence of existing partners willing to share responsibilities; and/or alignment with RAE Key Performance Indicators (KPIs), incentive measures, or population health priorities. **NHP** stated that the region’s transition to a new RAE was a challenge as the RAE was a new partner in collaboratives based on many long-standing established relationships within the region. **NHP** had to build trust of the RAE system with new partners. In the region’s rural ranch-oriented culture, each partner must bring something of value (e.g., resources) to the communities in order for the door to be opened for engaging in initiatives. **NHP** has approached each Health Neighborhood activity with the intent of determining what the RAE can contribute to the collective objectives of each collaborative. **NHP** reported that the RAE’s role is most often sharing of Medicaid data and provision of care coordination resources. **NHP** reported that the stimulus for bringing together organizations to participate in Health Neighborhood ventures is based on “value-added” criteria—i.e.,

shared interests or concerns, shared goals that reflect something of benefit to all, improving cost efficiencies.

At the inception of the RAE, **NHP**'s partner organizations were already participants in many existing Health Neighborhood collaboratives. As such, **NHP** is engaged in a mix of established coalitions, as well as RAE-initiated activities as follows:

- **NHP** is participating as a mandated partner in **Interagency Oversight Groups (IOGs)** targeting at-risk youth involved in multiple systems of services in the region. **NHP** and the IOGs are examining the overlap in IOG and RAE performance measures, such as mental health measures and KPIs, and sharing data to benefit both organizations. Challenges and opportunities encountered to date include:
 - IOGs serve the broad population, while RAEs serve only Medicaid, creating a gap in what the RAE can provide to IOGs.
 - While RAE KPIs are specifically defined, IOG data are very broad and IOGs lack sophisticated data collection systems.
 - The Department of Human Services (DHS) structure in the region is complex. The statewide child welfare forum, which engages DHS and the Department in discussions, is considered essential in facilitating regional efforts.
 - The RAE can use the IOG platform to educate agencies about the RAE and population health initiatives.
- The **Community Action Collaborative (CAC)** consists of 22 participating community agencies in the Weld County area, including numerous criminal justice-involved agencies and organizations, DHS, NRBH, North Colorado Medical Center (NCMC), and several social support service organizations. Objectives of CAC include:
 - Providing prevention services, crisis stabilization, emergency department (ED) diversion, and wraparound care resources to reduce emergency encounters such as ED visits and to decrease frequency of jail admissions.
 - Providing interagency support to CAC partners in working with individuals who are lingering in systems.

As one initiative to address these objectives, the CAC has configured a multidisciplinary team consisting of Greeley Fire Department paramedics, NRBH-licensed behavioral health (BH) clinicians, and NCHA care coordinators to intervene with members identified through interagency hot-spotter meetings. (The RAE contributes data regarding individuals that are identified as complex “impactable” members.) While the CAC develops a wholistic collaborative care plan for these members, the multidisciplinary team addresses the individual’s specific needs. Greeley Fire Department supplies an ambulance and paramedics and the mental health clinician and a care coordinator ride along on emergency medical system (EMS) calls to assess the member and refer the member to appropriate services, while diverting the member from unnecessarily using the ED. Staff members reported that each client responds differently to the individuals on the team. The RAE reported that, in 2019, the team experienced over 6,000 contacts with impactable members, completed 1,100 individual needs assessments, performed 73 home visits, and facilitated 40 provider visits. Fire department data indicated that the team performed 754 diversions and that the average

cost of responding to an EMS call had been reduced from \$680 to \$200 per call. The CAC is exploring how to expand this model to other communities in the region such as southern Weld County, Sterling, or Fort Morgan, although some rural communities may not have sufficient resources to implement the program.

- NCHA leads the **Northern Colorado Opioid Prevention Workgroup (NCOPW)** comprised of Larimer County and Weld County providers, community agencies, CMHCs, and judicial entities to reduce the number of deaths from opioid overdose, reduce the number of opioid addictions, and to prescribe opioids safely. The NCOPW's defined objectives include: increasing access to Naloxone (Narcan), improving provider education, building criminal justice relationships, and adopting a model for medication assistance. NCOPW pursued and was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to provide care managers to target this high-risk population, promote Medication-Assisted Treatment (MAT) in jails, and provide care management for patients with opioid addictions. NCHA care managers received specialized training in addiction and assist members with social determinants of health needs and engagement in MAT services. NCHA also tracks recovery data—e.g., Narcan use—and reported successful outcomes with 84 percent of individuals remaining sober after three months.
- The **Colorado Opioid Synergy Larimer and Weld (CO-SLAW)** network is one of the most innovative approaches to substance use disorder (SUD) treatment in the State. As part of a multi-county, multi-system model of care, the CO-SLAW network of eight healthcare providers offers robust MAT services; targets care coordination for persons on MAT; and supports transitions of care between local hospitals, EDs, and incarcerated settings. NCHA care managers refer individuals to CO-SLAW for connection to treatment and co-manage the member's care plan.
- Salud develops partnerships with schools in Region 2 to increase access to screening, fluoride treatment, sealants, and a virtual dental home in the school setting. From August to December 2019, Salud saw 1,778 children in **school-based dental programs** in Region 2. Salud meets semiannually with the Northeast Colorado Health Department to ensure efforts to provide access to dental services are collaborative and not duplicative across the region. In the last 12 months, **NHP** has increased partnerships with three school districts to increase dental interventions among students. Specific examples included:
 - A collaborative agreement between the Platteville school, Sunrise Community Health Center, and Salud to provide a sealant program to students, ensuring children are connected to a dental home.
 - In Fort Morgan, Salud recently added two schools as part of the virtual dental home model (SMILES project).
 - Salud dental providers offer screening and fluoride treatment to participants in the Fort Lupton Boys and Girls Club.
- NCHA engages numerous stakeholders—BH providers, FQHCs, UCHealth, DHS, local universities, and other health providers—in a collaborative initiative to provide **school-based health and wellness programs**. Supported by the Healthy Schools Grant program, NCHA provides direct staff time, resources, and referrals for staff members and students in five rural school districts in Weld County. The partnership objectives include assessing and addressing barriers to health, providing professional development, updating wellness policies, and writing comprehensive health and

wellness plans for each district. Data-driven decisions guide the provision of resources for health and wellness that align with the “Whole School, Whole Community, and Whole Child” model.

NHP has initiated or participates in additional Health Neighborhood activities that address the RAE’s impactable populations. Such initiatives are outlined in the “Other Health Neighborhood Initiatives” section of this report.

Improving Access to Specialist Providers

NHP stated that, similar to every other RAE and throughout the State, Region 2 experiences a general shortage of specialist providers for Medicaid members, with a particular shortage of pain management and spine therapy specialists. Due to a lack of adequate specialist tracking data, **NHP** conducted an access assessment with PCMPs to determine pre-existing referral patterns between PCMPs and specialists. Most PCMPs in the eastern rural areas of the region refer to specialists in Fort Collins, Greeley, or Denver. The RAE initiative to obtain signed compacts between specialists and PCMPs created huge issues in the region, resulting in specialists not wanting to participate in Medicaid. NCHA met with specialists in the community and identified that member no-shows for appointments, lack of member preparedness for appointments, or lack of follow-up care were major concerns. If NCHA care coordinators know of an upcoming specialist appointment, they will work with individual members to prepare for an appointment, accompany many members to appointments, and will assist the member with follow-up support services and medications. Staff members stated that transportation issues remain a problem for members throughout the regions. As the State’s Non-Emergency Medical Transportation (NEMT) vendor is unreliable, care coordinators repeatedly advocate for individual members with the NEMT provider. NCHA also maintains a direct billing account with Uber and Lyft, which is supported through donations. NCHA has educated PCMPs throughout the region to encourage referrals to care coordination for members with upcoming specialist appointments. Staff reported that anecdotal feedback from providers indicates that relationships with specialists have improved due to referrals to NCHA, and that some specialists are also making referrals to care coordinators.

Other than BH specialists, the RAE has no leverage with specialists and cannot recruit specialists to work in the region. Feedback from specialists related to increasing access for Medicaid members indicates that poor Medicaid reimbursement and cumbersome Medicaid administrative requirements are significant deterrents to specialists’ increased participation in Medicaid. Banner Health (Banner) is the largest provider of specialty care in the region through its affiliated specialist practices; however, Banner also has affiliated primary care groups who have priority access to these specialists, competing with access by other PCMPs. Both Banner and UCHHealth provide rotating specialists and specialty clinics in some rural areas of the region. A relationship with the Colorado University (CU) School of Medicine enables specialist telehealth services to be provided in the region. Staff members stated that Lincoln Community Hospital is the only hospital and only option for care in its area (Limon), and offers emergency and in-patient services while also coordinating visiting specialists from around the State—cardiology, plastic surgery, obstetrics-gynecology (OB-GYN), oncology, hematology, BH—to offer services in the community. **NHP**’s local PCMP—Peak Vista—actively refers patients through this program, enabling Medicaid patients who otherwise would have barriers to seeking specialty care to

have local solutions to meet their healthcare needs. **NHP** noted that other visiting specialist programs had been organized in Kit Carson County, Holyoke, and Sterling. Staff members reported that the region's mobile MAT unit will also be participating in the visiting specialist programs.

Due to a shortage of psychiatrists throughout the region, **NHP** has engaged Colorado Psychiatric Access and Consultation (C-PAC) to provide telehealth consultation services to PCMPs. Data tracking of utilization of C-PAC's services indicates a 90.4 percent utilization rate among **NHP** providers. **NHP** stated that the C-PAC program is used by providers throughout the region and is especially well-received in rural practices. **NHP** conducted a PCMP practice survey in which 100 percent of providers stated that C-PAC met their needs and 100 percent of providers believed that C-PAC improved behavioral healthcare for members.

Collaborative Initiatives with Hospitals

Region 2 has 11 active Hospital Transformation Programs within its service area. At the time of on-site review, all hospitals had selected and submitted their Hospital Transformation Program (HTP) initiatives and measures to the State. In all HTPs, the RAE's primary role has been focused on data-sharing and provision of care coordination to support initiatives. While the RAE is required to be a participant in all HTPs, **NHP** reported that the RAE's level of involvement varies widely between the larger and smaller hospital systems in the region. **NHP** provided contrasting examples:

- The Banner hospital system, with several hospital locations in the region, is working on HTP through its Quality Management Group and is not as directly engaged with the RAE as other systems. **NHP** maintains an active relationship with UCHealth hospitals, although **NHP** reported recent staff changes in UCHealth leadership who are re-establishing new relationships with **NHP**. Both UCHealth and Banner have conducted HTP planning electronically rather than through group meetings. **NHP** noted that historical and ongoing political and competitive issues between Banner and UCHealth present a challenge for the RAE.
- In the outlying rural regions, hospitals are very small and often connected with outpatient clinics. In addition, the limited staff resources in rural areas result in individual leadership positions that span several areas of responsibility. HTP collaboratives in rural areas address the needs of all members of the communities they serve, not just Medicaid. HTP discussions in rural communities evolve into broadly addressing all aspects of the relationship between the RAE and the hospital-based health system in the community. Related to data-sharing, the small rural hospitals lack sophisticated health information systems (some relying on manual record keeping), need funding to improve their data systems, and have a smaller set of HTP measures that can be achieved. In addition, examination of RAE data involves analytics—sometimes at the individual member level—as many hospitals are already personally aware of individual member's utilization patterns—e.g., ED use—within their communities. Social determinants of health are a major focus of HTP initiatives in smaller communities. Related to HTP initiatives, mental health resource needs are among the top three priorities of every small community. In addition, initiatives commonly seek to improve referral and communication mechanisms to integrate hospital care, outpatient care, and community resources.

Despite the differences between the large hospital and rural hospital HTPs, **NHP** stated that all HTP collaboratives are led by the hospitals and address the objectives and priorities established by the collaborative participants. Nevertheless, some of the priorities of each HTP align with RAE KPIs or the care coordination priorities of the RAE—i.e., management of complex members. **NHP** provided an example of Banner’s interest in improving management of high-risk pregnancies in the Medicaid population. To that end, Banner has established a physician residency program in Sunrise clinics. In addition, Banner has established high-risk prenatal clinics for the refugee population. The RAE provides care coordination services for members treated in these clinics. Some of the RAE’s other Health Neighborhood initiatives (outlined in this report)—e.g., C-PAC and mobile MAT unit—similarly align with HTP priorities.

All HTP initiatives are in early stages of implementation and outcome measures are premature. Furthermore, **NHP** reported that all HTP activities had been temporarily suspended due to coronavirus disease 2019 (COVID-19) priorities.

Other Health Neighborhood Initiatives

NHP defines impactable populations as the two upper tiers of the RAE’s stratified population—complex care members and members with select chronic conditions—as defined by the Department. **NHP** uses additional member data—i.e., the Johns Hopkins impact analysis assessment tool—to select out of those tiers the categories of members that are most impactable. **NHP** noted that some members of these populations do not want help and decline being involved with care coordination. **NHP** has initiated collaborative projects with Health Neighborhood partners to address impactable populations. Examples include:

- Initiated by **NHP** to address RAE KPIs—increasing screening for BH needs of foster care children; increasing engagement in dental services, **NHP**’s partner FQHCs, NRBH, NCHA, and Weld County DHS have collaborated to develop a **Foster Care Pilot Program** to bundle services and offer one-stop integrated care for foster care children through the FQHCs. Sunrise and Salud offer program members a bundled appointment for physical health, BH, medication management, and dental services to reduce barriers and improve access to care. NCHA care coordinators follow up with members after the appointments and manage ongoing member and family needs. DHS provides referrals to the program. Bundled appointments allow one-stop care through integrated care FQHCs. For members receiving care through other PCMPs, NCHA care coordinators coordinate appointments for members. **NHP** reported that foster parents, who are often overwhelmed with the requirements of caring for one or more foster children, have been very receptive to the program. **NHP** identified that foster care children from Region 2 who are placed in homes in the Denver area create challenges for the RAE in addressing the needs of children with complex BH needs; Denver-area providers not associated with **NHP** are unwilling to care for these members due to payment issues.
- **NHP** has engaged UHealth, NCMC, and NCHA to establish a **Palliative Care Coalition (the Coalition)** to identify and provide services for members who may qualify for outpatient palliative services. The objectives of the Coalition are to: reduce hospital re-admissions while improving an individual’s quality of life through symptom management of chronic or complex conditions,

evaluate and resolve gaps in services among all levels of care, and provide education to increase awareness in the community. The Coalition also invited the participation of Kaiser Permanente and several palliative service organizations. The Coalition's progress was temporarily suspended due to COVID-19 restrictions and priorities.

- Motivated by **NHP**'s KPI and shared interest of partners, **NHP** is collaborating with the Women, Infants, and Children (WIC) Program, Nurse Family Partnership, Prenatal Plus, and Healthy Communities in developing **Cross-Agency Coordination for Weld County Prenatal Members**. Early meetings identified that agencies were duplicating outreach efforts to pregnant women, indicating the need for collaboration among these programs to simplify the referral process and tighten linkages between programs. The collaborative has examined options for creating a "no wrong door" entry into services and the potential for cross-agency co-management of mutual members. Outcome objectives of the collaborative are to: increase prenatal engagement with routine OB care, use existing community services to wraparound higher risk OB members, improve integration of BH services, decrease the incidence of ED use, and decrease maternal-newborn morbidity.
- Salud is a training site for the **New York University Langone Hospitals Postdoctoral Dental Residency Program (NYU Langone Dental)**. This program uniquely advances residents' skills in general dentistry well beyond a traditional program. In addition to treating children, adults, and the elderly, the residents are trained to treat populations that present with intellectual and/or developmental disabilities and a variety of medically complex conditions. The residency program increases access to dental services in Region 2, providing between 1,500 and 2,000 visits each year.
- NCHA attends and participates in **Community Action Team (CAT)**, which is addressing prenatal care management, sleep safety, and pre-pregnancy education.

What the Department Can Do

NHP recognizes that not all Medicaid objectives can be met through the individual RAEs and are better addressed by the Department or through statewide collaboration between the Department, other agencies, and the RAEs. **NHP** noted the DHS/Department collaborative as a positive example of much-needed State-level activity. **NHP** recommended the following additional opportunities for the Department's consideration:

- In relation to emerging telehealth technology, there are many different options and platforms available resulting in a piecemeal approach among the RAEs for delivery of telehealth services. **NHP** recommends that the Department consider:
 - Bringing together all options available statewide for delivery of telehealth services.
 - Exploring the use of telehealth to address the shortage of SUD services, controlling for the quality of SUD services.
 - Researching funding sources for improving the technology available in rural areas, including information system platforms as well as consistent access to the Internet.

- **NHP** recommends that the Department develop mechanisms for sharing more data, including real-time data, among Medicaid agencies and providers. (Without real-time data, some targeted measures and interventions cannot be met.)
- Recognizing the limited capabilities of individual RAEs to improve access to specialists, **NHP** recommends that the Department provide more information to RAEs on what the Department is doing statewide to improve access to specialists for Medicaid members.
 - In a related idea for the future, is it possible for the Department to use its data or organizational relationships to identify or encourage development of “Centers of Excellence” for specialist care of Medicaid members within the regions?

NHP also identified general recommendations for the Department that would facilitate the RAE’s collaborative Health Neighborhood efforts.

- **NHP** stated that progress in Health Neighborhood activities is sometimes inhibited by the past history of collaborative participants that result in difficulties moving things forward to focus on solutions. In addition, **NHP** noted that there appear to be multiple forums for Health Neighborhood providers to communicate or file complaints with the State instead of dealing directly with the RAE. To that end, **NHP** suggested that the Department work directly through the RAE regarding any issues that arise.
- **NHP** is receiving inconsistent messaging from the Department, with misaligned directives being received from different areas within the Department, and which is further aggravated by frequent staffing changes within the Department. The RAE requested that the Department improve its internal organization to provide consistent messaging to the RAEs.
- **NHP** suggested that the Department is too out of touch with members and the varying demographics of the RAE regions. **NHP** cited that members have the right to exercise choices in how or whether they utilize healthcare services or the services of the RAE. In addition, providers and communities in rural areas want to be recognized as “rural and different” and are not receptive to directives and expectations from a Denver-based metropolitan-minded governmental agency. As the RAE needs to consider these dynamics to be effective, **NHP** recommends that the Department similarly manage their expectations of the RAE(s) accordingly.
- **NHP** recommends that the Department simplify its communications with members—e.g., eligibility letters. Members do not read or understand current communications, making the RAE’s attempts to work with members more difficult.