COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Site Review Report

for

Colorado Community Health Alliance

Region 7

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2018–2019 site review activities for **Colorado Community Health Alliance Region 7 (CCHA R7**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2018–2019 compliance monitoring site review. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the care coordination record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2018–2019 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol. Appendix F includes the summary of the focus topic interviews with RAE staff members used to gather information for assessment of statewide trends related to the 2018–2019 focus topic selected by the Department.

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	11	11	11	0	0	0	100%
IV. Member Rights and Protections	7	7	7	0	0	0	100%
V. Member Information	19	14	12	2	0	5	86%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	6	2	0	0	75%
Totals	**45**	**40**	**36**	**4**	**0**	**5**	**90%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

CCHA holds the RAE contract for both Region 6 and Region 7; therefore, policies and procedures, systemwide processes, and many written materials applied to both regions. Similarities included the organizational model for care coordination (CC) services, although CC staff are locally employed and located within Region 7. **CCHA** was not the previous Regional Care Collaborative Organization (RCCO) or Behavioral Health Organization in Region 7; therefore, all Region 7 CCs were newly-hired employees of **CCHA** prior to initiation of the RAE contract. Some CC program management staff have responsibilities in both regions, and extensive collaboration exists among CCs in Region 6 and Region 7. Significantly, **CCHA** hired the chief operating officer of the Region 7 RCCO, enabling transition of previously developed relationships and CC processes with community partners and providers in Region 7 from the RCCO to the RAE.

CCHA demonstrated numerous strengths in the organization and execution of CC for members with complex needs. **CCHA**'s CC program for members with complex needs was organized into care coordinator teams associated with specialized program areas—behavioral health (BH) transitions of care, complex care management, emergency department (ED) follow-up, justice-involved members, maternity, pediatric and foster care, medical transitions of care, and member support services. Each program had an integrated team of nurses, social workers, behavioral health practitioners, Member Support Services staff, and peer specialists organized to meet the needs of each member. Members were assigned to a program team according to individual needs and goals. **CCHA**'s CC policy addressed all CC program requirements for acute, complex, and high-risk members and was supported by procedures outlined in program descriptions for each specialized program area. **CCHA** has also maintained co-located care coordinators strategically throughout the region, including: Sunrise Healthcare (primary care medical provider [PCMP]), Summit Medical Clinic, AspenPointe Acute Treatment Unit (ATU), Peak View Behavioral Health, Cedar Springs Hospital, county probation office, Family Court, and Marion House Soup Kitchen. The RAE has also maintained a close working relationship with UCHealth Memorial Hospital Central (Memorial Hospital) and Penrose Hospital and reported that **CCHA** is near placement of co-located CCs in those facilities. Unique to Region 7 is the previously established working relationship with El Paso Department of Human Services (DHS). Located in the same building with all other State and county agency offices, the co-located senior member support specialist "coordinates the coordinators" of the various agencies. **CCHA**'s pediatric program CCs also maintain close working relationships with DHS.

CCHA delegated CC to two PCMP partners—Accountable Care Network (ACN)—including Peak Vista Community Health Centers and Mathews-Vu Medical Group. **CCHA** estimated that 50 percent of the region's members were offered CC through Peak Vista and 11,000 through Mathews-Vu. Mathews-Vu is also acquiring many provider practices and expanding its Medicaid membership. **CCHA** outlined delegated CC responsibilities in an ACN provider contract with each entity, which detailed the provider's required capabilities to perform comprehensive CC for RAE members. **CCHA** maintained the responsibility for CC for all BH inpatient cases. In addition, if a member was extremely complex,

CCHA would co-manage the case with the ACN partner. **CCHA** conducted oversight of ACN contractors through ACN deliverable reports of high-level CC activities (for reporting to the Department), high-level outcome data—e.g., monthly performance monitoring of ED visits and monthly meetings with ACN program managers. Staff members stated that ACN providers, the single-entry point (SEP), and community centered board (CCB) also participated in **CCHA**'s performance improvement advisory committee (PIAC) meetings.

CCHA monthly reviews PCMP claims data to verify that utilization correlates with attributed members. Practice transformation coaches, hired by **CCHA** to support regional PCMPs, initially assisted PCMPs with attribution issues, which opened the door for **CCHA**'s provider relations staff to work with the PCMPs. Practice transformation coaches trained providers to verify patients in the Medicaid eligibility portal to identify whether members were correctly attributed to the PCMP and to assist individual members with reattribution when necessary. **CCHA** distributed to practices enrollment cards that include the Health First Colorado (HFC) enrollment broker contact number for members to call to request a change to a different PCMP. In addition, providers may refer a list of mis-attributed members to the **CCHA** Member Support Services staff, who outreach to all listed members to assist each with reattribution to a new PCMP by conducting a warm handoff call with the member and HFC enrollment broker. Ongoing, **CCHA** processes for each provider a report of verified and unverified (i.e., no claims history with the attributed provider within the past 24 months) members. **CCHA**'s tiered per member per month (PMPM) reimbursement is tied to the verified and unverified lists, thereby incenting providers to outreach to unverified members to schedule an appointment or to assist the member with reattribution to another PCMP. Staff members stated that following initial implementation of the Department's new attribution methodology, **CCHA** identified several system-level issues contributing to incorrect member attribution, including: pediatric members were assigned to adult-only practices; the high number of members previously unattributed in the RCCO were assigned to PCMPs with established limits on Medicaid panel size (resulting in lack of PCMP capacity to absorb newly attributed members); members residing in Park County, which has no PCMPs located in the county, were assigned to PCMPs far from their homes. **CCHA** worked with the Department to remedy macrosystem issues and reported that system-level attribution issues have significantly improved over recent months.

CCHA ensured that members with behavioral health needs—identified either through calls to member services, stratification data, member services outreach assessments, or CC contacts—were each aligned with a behavioral health provider, and notified each member of the contact information for the aligned provider. Staff members stated that many RAE members requested alignment with the expanded network of IPN BH providers. **CCHA** provided a business card with the lead CC's picture and contact information to each member involved in CC; CCs also accessed information regarding a member's assigned PCMP and ensured that the member had contact information for the PCMP. **CCHA** distributed pocket ID cards to each member that included a blank for the member to complete the name and phone number of their primary care provider.

CCHA's CC policies and program procedures and the ACN contract outlined provision of deliberate CC interventions based on members' needs and goals and provision of longitudinal ongoing CC with other aspects of the health system to coordinate services addressing members' health and social needs. For members not engaged in **CCHA** complex CC, the member's medical home provider was responsible to coordinate care for members. Practice transformation coaches assisted PCMPs to identify CC resources within each practice; staff members stated that PCMPs could also refer any member to **CCHA** CCs at any time. **CCHA**'s program descriptions outlined procedures for coordinating services between settings of care, with Medicaid FFS programs, and with community support providers. **CCHA** had established formal memorandums of understanding (MOUs) with Rocky Mountain Rural Health (Park County) and Aspen Mine Center (Teller County) to provide patient navigation services and resource referrals for members in the rural areas of Region 7. Staff members stated that RAE CCs statewide bi-directionally referred and shared coordination of care information for members transitioning from one RAE to another. Region 7 CCs most commonly coordinated services with **CCHA** Region 6 and HCI Region 4. The ACN contract required that the provider use transitions of care as a trigger for CC. **CCHA** and the ACN had collaborated on workflows to partner for care management of BH members.

Staff members described that Region 7 has a well-established network of community agencies and providers that collaborate to improve services for members in the community. The RAE has maintained relationships previously established through the RCCO with community partners for CC and continues participation in collaborative community program initiatives. Collaborative management memorandums of understanding (MOUs) with each of El Paso, Park, and Teller counties described local-level, multi-agency oversight groups for child welfare, education, homeless, juvenile justice, and mental health systems to address needs of at-risk children and youth. Individualized service and support teams (ISSTs) coordinated and managed provision of services to children and families through integrated multi-agency service plans. **CCHA** also had an MOU with The Resource Exchange (CCB) to collaborate on filling gaps in services for children and adults with intellectual and developmental disabilities. In addition, staff members described that Peak Vista has numerous relationships with community resources and actively participates in community collaborative initiatives.

CCHA's *Enrollment Broker HNS Workflow* demonstrated daily transfer of the Department's member health needs survey (HNS) into **CCHA**'s data warehouse and CC tool. Member Support Services staff used the results of the survey to outreach to and onboard members, conduct a **CCHA** needs assessment, assist with correct attribution to PCMPs, and arrange services as indicated in assessment results. **CCHA** reported that, since implementation of the RAE, fewer than 30 Department HNSs had been completed by Region 7 members. In addition, Member Support Services staff attempted outreach to every newly enrolled member to complete a **CCHA**-developed an adult or pediatric needs assessment—which incorporated and expanded upon elements of the Department's HNS—and referred members to needed services or to CC, as indicated. **CCHA** specifically targeted outreach to all members identified on the Department of Corrections (DOC) list, Colorado Overutilization Program (COUP) list, newly enrolled foster care clients (identified through DHS), and referrals from Healthy Communities (HC) to identify members requiring continuity of care. Members requiring continuity of care were referred to a CC who worked with utilization management (UM) staff, other RAEs, and the member's existing providers as necessary to ensure continuity of care for newly enrolled members.

Any member triggered for complex CC through Member Support Services, stratification data, or provider or community referrals received a comprehensive needs assessment. **CCHA** had developed an extensive complex care management assessment as well as more than 20 additional needs assessment tools specific to the specialized needs of the member or the specialized CC program area—e.g., BH, maternity, alcohol use disorders, drug abuse, postnatal depression, geriatric depression, and fall risk. CCs used the results of assessments to develop a service plan for each member. All member CC information, including all elements required in the RAE contract, was documented in **CCHA**'s Essette care management software (Essette). CCs shared results of assessments and the CC plan with other providers involved with each member's care through secured faxed copies from the Essette system. Staff members stated that **CCHA** was developing a secure provider portal to enable direct provider access to Essette CC information. The ACN contract also outlined CC elements required to be documented in the delegated entity's electronic health record or CC tool. **CCHA** demonstrated that it had audited each ACN CC system to ensure compliance with required elements. **CCHA** required compliance with member privacy regulations through policies and procedures, provider contracts, provider manuals, and business associate agreements incorporated in CC MOUs.

Summary of Findings Resulting in Opportunities for Improvement

While the ACN contract adequately addressed many defined CC requirements, HSAG recommends that **CCHA** consider strengthening or better detailing in the ACN contract requirements related to defined federal managed care regulations. Examples include requirements for: coordinating services with other managed care plans, Medicaid FFS, and community support organizations; conducting an intake assessment and developing a related service plan for all members receiving BH services; ensuring continuity of care for BH members involved in multiple systems or transitioning from other delivery systems; and sharing assessments of member needs with other entities involved with the member.

HSAG recommends that **CCHA** develop and implement a comprehensive ACN CC audit tool to ensure that ACN providers are adequately performing CC for members consistent with **CCHA**'s expectations (e.g., the quality and depth of CC information in the ACN's electronic health record), requirements outlined in the ACN contract, and managed care regulations.

While **CCHA** demonstrated having comprehensive CC services for members with complex needs, members with less intensive CC needs were managed through the PCMP and BH providers. As such, HSAG recommends that **CCHA** more explicitly address in the physical health (PH) and BH provider manuals CC federal managed care requirements applicable to providers. Examples include the BH provider's responsibility to conduct an intake assessment and develop a related treatment plan for all members as well as the responsibility of both PH and BH providers to share results of assessments with other providers involved in each member's care.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

CCHA submitted numerous policies and procedures that together outlined the health plan's efforts to define and uphold member rights. Within its policies, **CCHA** listed the rights and responsibilities of members divided into five categories including: rights related to the provision of quality medical care, grievance rights, State fair hearing rights, rights pertaining to privacy and medical records, and member responsibilities. Policy and procedures addressed all member rights, as defined in the State contract and afforded members under 42 CFR 438.100. **CCHA** outlined within its policies how members and providers were informed of their rights. HSAG found evidence of the distribution of rights to members and providers within the PH provider manual, BH provider manual, HFC Member Handbook (linked to the **CCHA** website), and directly on the **CCHA** website under the headings "Member Benefit Services" and "Frequently Asked Questions." In addition, policies and procedures outlined **CCHA**'s compliance with other federal or State laws concerning member rights pertaining to race, age, gender, ability, and the like.

Ongoing, **CCHA** tracked and trended member grievances to determine grievances that were potential member rights violations. **CCHA** was able to review rights-related grievances to determine need for enhancements internally related to member communications or member support services. Additionally, **CCHA** examined possible need for general provider education or additional outreach to specific providers.

CCHA maintained written policies and procedures pertaining to advance directives and provided written information to members. **CCHA**'s policies and procedures addressed all required components, including a statement that **CCHA** had no limitations related to the implementation of an advance directive as a matter of conscience. This statement was available to providers in the PH provider manual and the BH provider manual. **CCHA** also had provisions for providing members with information on advance directives, evidenced through the on-site coordination of care case reviews. Care coordinators and peer support specialists helped members with advanced directives by providing information and encouraging the completion of written advance directives, Five Wishes documentation, and behavioral health advance directives; and by encouraging members to discuss such with providers and family members. Education about advance directives was also available to members and the general public on the **CCHA** website. During the site review, the **CCHA** communications manager noted that the advance directives information available through the **CCHA** "Health Topics" webpage is one of the most accessed subjects in the **CCHA** health topics library.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings that resulted in opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

CCHA provided required member information in a manner and format accessible to members with varying ability and command of the English language, including those unable to communicate fluently in English or with vision or hearing impairment. **CCHA** tested written and electronic information with its Member Advisory Committee prior to distributing the information to members or posting information on its website. The **CCHA** communications manager described the process for testing member information and ensuring that content in English and Spanish used language that was easily understood. The process included passing multiple drafts through a diverse committee of members until content and format consensus was reached. In addition, **CCHA** staff members worked with the Member Advisory Committee using various focus group discussion techniques to learn about the member population at large and to refine or develop materials to help ensure that members were receiving and understanding necessary information.

During the site review, staff members noted that requests for American Sign Language (ASL) translation were relatively high. **CCHA** was able to meet such requests through a contracted service. Language translation services were also available to members at each point of contact, upon request. **CCHA** contracted with a vendor for language translation services and was able to review billing information from the vendor to track trends in language usage.

CCHA had several mechanisms in place to help members understand the benefits and requirements of their plans. Members who preferred communicating over the phone could call Member Support Services and speak directly with a person locally to resolve any questions or concerns. Members who preferred online access to information could find benefits and requirements on the website under the heading "Member Benefit Services" in the "Frequently Asked Questions" section and in the HFC Member Handbook (linked to the **CCHA** website). **CCHA** also published a member guide that was handed directly to members at various in-person points of contact.

The layout of the **CCHA** website was easily navigable by members. On its website, **CCHA** provided members with access to its provider directory; the Department's formulary; the Health First Colorado nurse line; and Colorado Crisis Services information. Resources on the website provided members with an overview of the basic features of **CCHA**, member benefits, CC, and how to obtain CC. The website also had a "Contact Us" page which included various methods to contact **CCHA**, including a form that could be completed and submitted electronically. Items on the website were printable, and the website notified members that upon request **CCHA** would mail any website information. Physician incentive

plans were available to members upon request. **CCHA** provided HSAG with a provider incentive document that could be made available to members upon request.

Summary of Findings Resulting in Opportunities for Improvement

HSAG recommends that **CCHA** complete its planned review of the **CCHA** website with its Member Advisory Committee to gather information about how members perceive the website's ease of use.

Summary of Required Actions

HSAG evaluated **CCHA**'s website, CCHAcares.com, using the WAVE accessibility tool and found that a sample of webpages contained both accessibility and contrast errors. **CCHA** must ensure that the content of its website is fully readily accessible per Section 508 guidelines.

HSAG evaluated **CCHA**'s website, cchacares.com, for machine-readability using the WAVE web accessibility evaluation tool and found that the searchable provider directory contained significant accessibility and contrast errors. **CCHA** must ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 standards.

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

Summary of Strengths and Findings as Evidence of Compliance

CCHA holds the RAE contract for both Region 6 and Region 7; therefore, policies and procedures, systemwide processes, and many written materials applied to both regions.

CCHA informed members about EPSDT benefits through the member website, HFC member handbook, and a link to the HFC EPSDT fact sheet. **CCHA** also distributed hard copies of the EPSDT fact sheet to members at various points of contact with members and families; these included during CC, at provider office visits, and through DHS child welfare community partners. Staff members stated that **CCHA** considered individual member contact more effective than mass communications to educate members on EPSDT benefits and services. The Essette CC system flags new enrollees who are children to remind CCs to ensure that families are educated on EPSDT benefits. EPSDT benefit information is also incorporated into the CC pediatric needs assessment tool. In addition, **CCHA** described a process of distributing to each PCMP an "unverified" list of members attributed to the practice but had not experienced any claims-based contact with the practice for the past two years. Providers were incented to outreach to those members—a subset of which could be children and youth eligible for EPSDT services—to encourage scheduling a well-care appointment with the provider. Staff members described that future plans to educate members included a member outreach campaign for all members stratified in

CC Quadrant 1 (healthy members) to engage those members in scheduling well-care visits as well as development of a printed EPSDT-specific insert to be included in **CCHA**'s *Map to Medicaid* brochure distributed to members through various member touchpoints.

CCHA educated providers on EPSDT benefits through provider manuals, provider newsletters, and information on the provider website and linked providers to the HFC website for more information. The March 2019 provider newsletter informed providers of EPSDT benefits and linked providers to the HFC EPSDT training webinar. Region 7 conducted a joint BH/PH provider town hall meeting and distributed a variety of program materials, including the EPSDT fact sheet. **CCHA** educated practice transformation coaches on EPSDT benefits to serve as conduits for training individual PCMPs on EPSDT. Provider key performance indicators were aligned with achieving well-child visits outlined in the periodicity schedule. Staff members stated that future plans for updating providers on EPSDT benefits included incorporating training webinars in joint PH/BH town hall meetings, retaining such webinars on the training page of the provider website, implementing training through the soon-to-be-implemented provider portal on the website, and including EPSDT as a formalized agenda item during "open-mic" sessions with providers.

CCHA's EPSDT policy and provider manuals included the accurate definition of "medical necessity criteria for EPSDT services." Staff members stated that UM reviewers had been trained on the expanded definition of "medical necessity for EPSDT services," and the UM manager monitored all notices of adverse benefit determination applicable to EPSDT-eligible members. In addition, Region 7 local UM staff and medical directors regularly interact with CCs and participate in integrated rounds to discuss complex cases potentially related to EPSDT benefits.

CCHA met with HC contractors in El Paso, Teller, and Park counties on several occasions and finalized MOUs with each county for onboarding newly enrolled Medicaid members. **CCHA** and HC contractors had established a high-level workflow to conduct an enrollment screening and refer members as appropriate to an elevated level of CC at **CCHA**. MOUs also outlined the commitment of **CCHA** and HC contractors to continue working together to refine the workflow and define data exchange processes. Staff members stated that Teller and Park counties have small HC staffs, and therefore outreach most members through mailers of co-branded materials. These counties are looking forward to data from **CCHA** that will assist them in prioritizing members for onboarding. In addition, Healthy Communities staff housed at Memorial Hospital attempt to visit every Medicaid mother and baby born in El Paso County to provide information on the RAE and refer the mother and baby to **CCHA**'s maternity CC program.

CCHA's EPSDT policy outlined all requirements for provision of medically necessary behavioral health services for EPSDT-eligible members; some of these requirements—i.e., screening performed by a qualified BH provider, screening performed in a culturally sensitive manner, examinations recorded in the medical record—were addressed in the BH provider manual. Staff members stated that some BH EPSDT services were also provided by PCMPs, especially within those practices with co-located BH services. Staff described that a medical record audit tool—to be applied to ACN providers in year one and to BH providers in years two and three of the RAE contract—would include monitoring documentation of EPSDT elements.

CCHA demonstrated that it had processes for arranging provision of BH services covered in the State Plan or 1915 (b)(3) Waiver Services through the collaborative efforts of UM and CC staff. Most of these required services were available in the region through the community mental health center (CMHC). The El Paso DHS BH core providers delivered early intervention program services. Staff stated that Region 7 has no BH residential treatment facilities (RTF); RTF services must be arranged in Denver or other regions. **CCHA** participated regularly in community agency collaborative processes—including daily "integrated rounds"—with county DHSs as well as with the CMHC, SEP, and CCB—to explore solutions for individual members needing EPSDT State Plan or Waiver Services.

Summary of Findings Resulting in Opportunities for Improvement

While **CCHA** described various methods of providing information to RAE members regarding EPSDT benefits, HSAG noted that the information available on the member website was not located in a prominent area of the website and would not be easily identified by members seeking information on EPSDT. In addition, other EPSDT information distributed to members was associated with personal member contact points such as provider or care coordinator. HSAG recommends that **CCHA** improve visibility of EPSDT information on its member website and consider additional mechanisms to inform the broad population of RAE members of the benefits and services available through the EPSDT program.

HSAG recommends that **CCHA** consider shortening the verification timeframe for the "unverified" members list from two years to approximately one year for members ages 20 and under, so as to better coincide with the annual well-child visit required by the EPSDT periodicity schedule.

HSAG observed that the BH provider manual did not address any expected relationship between primary care and behavioral health providers to ensure provision of needed EPSDT screenings and services. Due to the fact that most EPSDT services are provided through the PCMP, HSAG recommends that **CCHA** consider outlining responsibilities for primary care and behavioral health providers to communicate, refer, or confer related to encouraging all EPSDT-eligible members to obtain necessary preventive health screenings.

While **CCHA** provided information and made available EPSDT trainings for providers through its provider website, provider newsletter, and both its PH and BH provider manuals, HSAG observed the following opportunities for improvement related to these resources:

- EPSDT information on the provider website was not prominently identified and was located in an area of the website that would not be intuitive for providers to access to obtain EPSDT information. In addition, the provider information included only a link to the Department's EPSDT fact sheet, did not describe **CCHA** expectations of providers or **CCHA** support resources, and did not refer providers to the provider manual or other resources for more information.
- The provider newsletter notified providers of the EPSDT program and linked providers to the Department's EPSDT training webinar; however, the provider website did not include a link to that same training.

- The PH provider manual "Provider Roles and Responsibilities" section described only the components of EPSDT screening services. The manual failed to explicitly state that providers are responsible for provision of EPSDT screenings and referrals, did not reference or link to the periodicity schedule, and did not include the diagnostic and treatment service requirement of the EPSDT program.
- The BH provider manual included in the appendix of definitions a description of EPSDT services and stated that **CCHA** will arrange for the specific behavioral health services outlined in the State Plan or 1915 (b)(3) Waiver Services. It did not describe the BH providers' responsibilities for provision of EPSDT-related services, did not describe the full array of EPSDT services, and did not refer to any other sources of information for providers.

HSAG recommends that **CCHA** consider intensifying its focus on EPSDT benefits and requirements for providers by enhancing its provider EPSDT information and training with more detailed and comprehensive content, elevating training and information to a more prominent place on the provider website, expanding the definition of EPSDT screenings and requirements for PH providers in the PH provider manual, and moving EPSDT information from the appendix to the body of the BH provider manual. HSAG also encourages **CCHA** to execute described plans to develop **CCHA**-branded information and trainings regarding EPSDT, maintain training information on the provider website, and use **CCHA** practice transformation coaches and provider relations personnel to formalize EPSDT trainings.

At the time of on-site review, **CCHA** had outlined with all HC contractors onboarding plans that included a workflow for agreed-upon levels of member outreach and assessment by both organizations. However, the MOUs did not detail specific *content* of member messaging and assessments performed by each party. HSAG suggests that **CCHA** continue to work with each HC contractor to define more detailed procedures to promote consistency in messaging and prevent duplication in onboarding activities; HSAG suggests appending such procedures to the MOUs.

CCHA described a variety of mechanisms to assist providers with resolving barriers related to EPSDT benefits. While both the PH and BH provider manuals described that **CCHA** provides assistance to providers and members, the manuals did not inform of who to contact within **CCHA** for assistance. In addition, the March 2019 provider newsletter did not inform providers of assistance available through **CCHA**. HSAG recommends that provider communications clearly designate that assistance is available through **CCHA** and inform regarding who to contact within **CCHA** for assistance in resolving problems related to EPSDT services.

Summary of Required Actions

CCHA's EPSDT policy addressed all requirements for provision of medically necessary behavioral health services for EPSDT-eligible members. However, neither **CCHA**'s BH provider manual nor other provider communications clearly documented the responsibilities of BH providers for provision of all required components of the capitated behavioral health benefits related to EPSDT, specifically—"provision of all appropriate mental/behavioral health developmental screenings" and "provision of

diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure." **CCHA** must enhance provider communications to ensure that BH providers understand all requirements for the provision of applicable EPSDT-related capitated behavioral health services for members ages 20 and under.

CCHA's *Clinical Criteria for Utilization Management Decisions* policy and procedure defined "medical necessity" using language that did not correspond to the most recent version of medical necessity criteria outlined in the Colorado Code of Regulations (CCR)—10 CCR 2505-10—8.076.8, 8.076.8.1, and 8.280.4.E.—including the EPSDT-specific medical necessity criteria. As such, it appeared that some medical necessity criteria important to authorization of EPSDT-related capitated behavioral health services may have been omitted, including those noted in bold below:

- 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 delivered in the most appropriate settings required by the client's condition.***
- ***Provides a safe environment or situation for the child.***

CCHA must ensure that medical necessity criteria for UM decisions pertaining to EPSDT-related services are consistent with **CCHA**'s EPSDT policy and correspond with the complete definition of "medical necessity" outlined in 10 CCR 2505-10—8.076.8, 8.076.8.1, and 8.280.4.E.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

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

Compliance Monitoring Site Review Methodology

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

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

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

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

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

Objective of the Site Review

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

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

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit*, the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities.	III.CCC.1_CCHA_Care Coordination Policy *CCHA has implemented a care coordination policy, in addition to care coordination procedures (as evidenced by program descriptions listed below) to ensure consistent coordination of care for all members (page 1).* *Further, CCHA's care coordination policy and program descriptions outline specific activities focused on acute, complex, and high-risk patients, and ensures that care coordination is accessible, provided at the point of care, and respects member references. In order to reduce duplication and address gaps, CCHA has also defined specific partnerships and co-locations to support care coordinators in collaborating with other service providers.* • III.CCC.1_Prog Description - CCHA Behavioral Transitions Of Care • III.CCC.1_Prog Description - CCHA Complex Care Management • III.CCC.1_Prog Description - CCHA Emergency Department • III.CCC.1_Prog Description - CCHA Justice Involved • III.CCC.1_Prog Description - CCHA Maternity • III.CCC.1_Prog Description - CCHA Member Support Services • III.CCC.1_Prog Description - CCHA Pediatric Foster Care • III.CCC.1_Prog Description - CCHA Transitions of Care III.CCC.1_Accountable Care Network Provider Contract Template *CCHA delegates care coordination to ACN providers. Tasks associated with this delegation, along with a list of ACN partners and associated contracts are outlined in the desk review form.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit B1—11.3.1, 11.3.7		
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit B1--None	III.CCC.2_CCHA Member Support Services Policy *CCHA has implemented a member support services policy, which outlines requirements for call center operations. This policy includes ensuring each member has an ongoing source of care, and that the member is informed of how to contact their designated person or entity (entire document.* *In addition to the policy, CCHA has implemented a member support services procedure as further evidenced by the program description listed below.* • III.CCC.1_Prog Description - CCHA Member Support Services III.CCC.1_CCHA_Care Coordination Policy *CCHA has implemented a care coordination policy, which includes ensuring each member has an ongoing source of care, and that the member is informed of how to contact their designated person or entity* (page 2). III.CCC.2_CCHA_Map_to_Medicaid_ENG	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III.CCC.2_CCHA_Map_to_Medicaid_SP *This document serves as a member guide, informing members of CCHA's care coordination services, and how to contact CCHA for assistance (entire document).* III.CCC.2_CCHA_Member_Enrollment_Card_R7_ENG III.CCC.2_CCHA_Member_Enrollment_Card_R7_SP *CCHA distributes customizable enrollment cards to members in both English and Spanish. This can be completed by the member or their care coordinator, and includes space to document their provider name and number, and their Health First Colorado ID#. CCHA distributed 7,792 cards since July 1 in Region 7.* III.CCC.2_CCHA_CC_Insert_ENG_and_SP *This insert provides information for members regarding CCHA's care coordination services.* III.CCC.2_CCHA_BH_Quick Reference Guide_ENG III.CCC.2_CCHA_BH_Quick Reference Guide_SP *This document, available in English and Spanish, serves as a quick reference guide for members about accessing behavioral health services.*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 1: Exhibit B1—6.8.1	III.CCC.3_Attribution Comparison *This document outlines CCHA's strategies to review attribution assignments, increase accuracy of assignments, and connect members without a claims history to their assigned PCMP (entire document).* III.CCC.3_CCHA_PCMP Payment Methdology_02112019 *CCHA has implemented a tiered per-member per-month payment methodology for PCMPs, which incentivizes providers to outreach members who do not have a prior claims history with the provider (entire document).* III.CCC.3_CCHA_Sample_PCMP Payment Report III.CCC.3_CCHA_Sample_PCMP Unverified Report *As previously mentioned, CCHA has a tiered PCMP payment methodology. These documents include sample payment reports, in addition to a sample list of unverified members. This information is provided to PCMPs on a monthly basis. PHI has been redacted from these documents, resulting in some blank cells (entire documents).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The RAE ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit B1—11.3.3.2	III.CCC.1_CCHA_Care Coordination Policy *CCHA has implemented a care coordination policy, in addition to care coordination procedures (as evidenced by program descriptions listed below) to ensure care coordination includes deliberate and extended interventions to coordinate with other aspects of the health system (page 1-2).* *Further, CCHA's program descriptions, ACN contract template, Healthy Communities memoranda of understanding (MOUs) and*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	practice support materials as outlined below provide evidence of CCHA's efforts to coordinate with other aspects of the health system. • Program Descriptions: ○ III.CCC.1_Prog Description - CCHA Behavioral Transitions Of Care ○ III.CCC.1_Prog Description - CCHA Complex Care Management ○ III.CCC.1_Prog Description - CCHA Emergency Department ○ III.CCC.1_Prog Description - CCHA Justice Involved ○ III.CCC.1_Prog Description - CCHA Maternity ○ III.CCC.1_Prog Description - CCHA Member Support Services ○ III.CCC.1_Prog Description - CCHA Pediatric Foster Care ○ III.CCC.1_Prog Description - CCHA Transitions of Care • MOUs ○ III.CCC.4_Healthy Communities at El Paso County_CCHA_Health Neighborhood_MOU_1.23.19 ○ III.CCC.4_Park_County_Public_Health_CCHA_Health_Neighborhood_MOU_10.30.18 ○ III.CCC.4_Teller_County_Public_Health_and_Environment_CCHA_Health_Neighborhood_MOU_10.30.18	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ III.CCC.4_Community of Caring_CCHA_MOU_07.01.18 ○ III.CCC.4_Community of Caring_CCHA_MOU AMD 1_1.1.19 ○ III.CCC.4_Rocky Mountain Rural Health Inc_CCHA_MOU_07.01.18 ○ III.CCC.4_Rocky Mountain Rural Health_CCHA_MOU AMD 1_1.1.19 • Sample Contracts ○ III.CCC.1_Accountable Care Network Provider Contract Template • Practice Support ○ III.CCC.4_R7PracSupportFY18-19 ○ III.CCC.4_2019 - CCHA PCMP Incentive Program	
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.	III.CCC.1_CCHA_Care Coordination Policy *CCHA has implemented a care coordination policy, in addition to care coordination procedures (as evidenced by program descriptions listed below) to ensure care is coordinated between settings of care, with services administered by any other managed care plan, with fee-for-service Medicaid, and with services from community providers (page 2).* *Further, CCHA's program descriptions and county collaborative management programs and single entry point (SEP) MOUs outlined below provide evidence of CCHA's collaboration with social service providers and efforts to coordinate services furnished to members.* • Program Descriptions: ○ III.CCC.1_Prog Description - CCHA Behavioral Transitions Of Care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit B1—14.3, 11.3.10, 11.3.5, 10.3.2, 10.3.4	○ III.CCC.1_Prog Description - CCHA Complex Care Management ○ III.CCC.1_Prog Description - CCHA Emergency Department ○ III.CCC.1_Prog Description - CCHA Justice Involved ○ III.CCC.1_Prog Description - CCHA Maternity ○ III.CCC.1_Prog Description - CCHA Member Support Services ○ III.CCC.1_Prog Description - CCHA Pediatric_Foster Care ○ III.CCC.1_Prog Description - CCHA Transitions of Care • MOUS: ○ III.CCC.5_El Paso County Collaborative Management_CCHA_MOU_7.1.18 ○ III.CCC.5_Park County Collaborative Management_CCHA_MOU_7.1.18 ○ III.CCC.5_Teller County Collaborative Management_CCHA_MOU_7.1.18 ○ III.CCC.5_The Resource Exchange_CCHA_Health Neighborhood MOU_11.28.18 III.CCC.5_CCHA Care Coordination Referral Form *CCHA distributes this form to providers and community partners as a vehicle to refer members to CCHA for care coordination.*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III.CCC.5_190306_AspenPointe Meeting Minutes_Final *To further demonstrate collaboration with other aspects of the health system, the meeting minutes included here provide an example of CCHA's collaboration with the local community mental health center (CMHC), to coordinate and streamline services for members being discharged from the inpatient psychiatric hospital.*	
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit B1—7.5.2–3	III.CCC.6_Enrollment Broker HNS Workflow *This workflow documents CCHA's process for daily intake of health needs survey data from HCPF, and the process for outreaching the member (entire document).* III.CCC.2_CCHA_Member Support Services Policy *CCHA's member support services policy includes information on the health needs survey outreach campaign (pages 2-3).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that: • Each member receives an individual intake and assessment appropriate for the level of care needed.	III.CCC.1_CCHA_Care Coordination Policy *CCHA's care coordination policy outlines expectations for intake and assessment of members (page 2).* III.CCC.7_CCHA_Care Coordination Intake and Assessment Policy *This document outlines CCHA's policy and procedure around the intake and assessment of members (entire document).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit B1—14.7.1.1-3	III.CCC.7_RAE PCP Collaboration Letter *This sample letter is used by care coordination to engage with other providers serving a member (entire document).* *Additionally, this requirement is further evidenced by CCHA's care coordination assessments, samples of which are provided below.* • III.CCC.7_AUDIT - Alcohol Use Disorders Identification Test • III.CCC.7_CCHA - BH Assessment • III.CCC.7_CCHA - CCM Assessment • III.CCC.7_CCHA - ED Assessment • III.CCC.7_CCHA Assistance Fund Assessment • III.CCC.7_CCHA Community Resources Referred • III.CCC.7_CCHA Maternity Assessment • III.CCC.7_CUDIT-R Cannabis Use Disorder Identification Test • III.CCC.7_DAST-10 Drug Abuse Screening Test • III.CCC.7_Edinburgh Postnatal Depression Assessment • III.CCC.7_GAD7 - Generalized Anxiety Disorder Screen • III.CCC.7_Geriatric Depression Scale (GDS) • III.CCC.7_MAHC 10 - Fall Risk Assessment • III.CCC.7_Medication Assessment • III.CCC.7_MMSE - Mini-Mental State Exam • III.CCC.7_MOCA - Montreal Cognitive Assessment • III.CCC.7_PAM Caregiver Assessment • III.CCC.7_PHQ-9 Depression • III.CCC.7_Safety Plan Assessment • III.CCC.7_SLUMS Assessment	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• III.CCC.7_TUG - Timed Get Up and Go Test *CCHA has implemented the following two assessments based on lessons learned from implementation of HCPF's health needs survey.* • III.CCC.7_CCHA - Adult HNA • III.CCC.7_CCHA - Peds HNA	
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the Member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit B1—None	III.CCC.1_CCHA_Care Coordination Policy *CCHA's care coordination policy includes that CCHA shares with other entities serving the member the results of its identification and assessment to prevent duplication of activities (page 2).* III.CCC.7_CCHA_Care Coordination Intake and Assessment Policy *CCHA's care coordination intake and assessment policy outlines expectations for sharing care plan information with other entities serving the member (page 3).* III.CCC.7_RAE PCP Collaboration Letter *This sample letter is used by care coordination to engage with other providers serving a member (entire document).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *CCHA's behavioral health provider manual outlines requirements for maintaining member health records (page 76, 85-88).* III.CCC.9_CCHA BH Provider Agreement Template *This behavioral health provider agreement template outlines CCHA's expectations for transferring medical records (page 7).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 1: Exhibit B1—15.2.1.1, 15.2.1.3, 15.2.1.4	III.CCC.10_Essette Screenshots *These are screenshots of CCHA's electronic care coordination tool which demonstrates the ability to collect member name, Medicaid ID, age, gender, race/ethnicity, name of entity/person providing care coordination, other entities serving the member, and stratification level (entire document).* III.CCC.10_CCHA_Risk Stratification Model *CCHA's four-quadrant risk stratification model is included as a reference.* III.CCC.7_CCHA_Care Coordination Intake and Assessment Policy *This policy outlines that CCHA's care coordination tool captures the information included in this requirement (page 3).* III.CCC.7_CCHA - CCM Assessment *This sample assessment, as contained in CCHA's care coordination tool, demonstrates collection of information that can be used to create a care plan and goals for the member.* *In addition to the documents listed above, CCHA looks forward to demonstrating this requirement during the case review.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The RAE ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(6)* Contract: 20.B Amendment 1: Exhibit B1—11.3.7.11, 15.2.1.2.2	III.CCC.1_CCHA_Care Coordination Policy *CCHA's care coordination policy outlines expectations for ensuring that, in the process of coordinating care, each member's privacy is protected (page 2).* III.CCC.9_CCHA_Privacy Policy *This document outlines CCHA's policy on privacy, ensuring that, in the process of coordinating care, each member's privacy is protected (entire document).* III.CCC.11_CCHA_Form_Auth to Release PHI_Transmit PHI_FINAL_090717 *CCHA uses this authorization form to release protected health information (entire document).* III.CCC.11_CCHA_Member Rights and Responsibilities Policy *CCHA's member rights and responsibilities policy outlines member rights as it pertains to privacy (page 3).* *In addition to the previous documents, this requirement is further evidenced by CCHA's provider manuals, provider contracts and MOUs.* • CCHA BH Provider Manual ○ https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf • CCHA PH Provider Manual	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	○ https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf • III.CCC.1_Accountable Care Provider Contract Template • III.CCC.9_CCHA BH Provider Agreement Template • III.CCC.11_CCHA PCMP Contract Template • III.CCC.4_Community of Caring_CCHA_MOU AMD 1_1.1.19 • III.CCC.4_Community of Caring_CCHA_MOU_07.01.18 • III.CCC.4_Rocky Mountain Rural Health Inc_CCHA_MOU_07.01.18 • III.CCC.4_Rocky Mountain Rural Health_CCHA_MOU AMD 1_1.1.19 III.CCC.11	

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit B1—7.3.7.1–2	*The following documents are all related to the member rights and protections specified in this standard. More information regarding which part of the document and the evidence to support compliance will be provided for each requirement, respectively.* IV.MRP.1_CCHA_Member Rights and Responsibilities Policy IV.MRP.1_ CCHA_Privacy Policy IV.MRP.1_ CCHA_Individual Access to Designated Record Set Policy IV.MRP.1_ CCHA_Member and Provider Materials and Website Policy IV.MRP.1_ CCHA_ADA Compliance for Network Providers Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit B1—7.3.7.3	IV.MRP.1_CCHA_Member Rights and Responsibilities Policy *Informing employees and providers of applicable member rights and their duty to observe and protect said rights is found in this document (page 2).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *The Behavioral Health Provider manual informs providers of member rights and responsibilities (page 96).* CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *The Physical Health/Primary Care Provider manual informs providers of member rights and responsibilities (pages 6-7).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.cchacares.com/for-members/member-benefits-services/ https://www.cchacares.com/for-members/frequently-asked-questions/ *The CCHA website, via the Member Benefits and Services page and Member Frequently Asked Questions page, provides members with information regarding member rights and their ability to exercise said rights without retaliation. Additionally, CCHA provides a link to the Health First Colorado Member Handbook to learn more.*	
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	IV.MRP.1_CCHA_Member Rights and Responsibilities Policy *This document contains the member rights found in this requirement (page 2-3).* IV.MRP.1_CCHA_Privacy Policy *This document provides information on an individual's right to access PHI as contained in a designated record set, as well as information regarding a member's right to amend their PHI (page 6-7).* IV.MRP.1_CCHA_Individual Access to Designated Record Set Policy *This document complies with this requirement as it outlines the policy for an individual to request access to or a copy of their PHI in a designated record set maintained by CCHA, along with the procedure to approve or deny a request (entire document).* https://www.cchacares.com/for-members/frequently-asked-questions/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit B1—7.3.7.2.1–6	*Member Frequently Asked Questions includes information on CCHA's access to care standards.*	
4. The RAE ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit B1—7.3.7.2.7	IV.MRP.1_CCHA_Member Rights and Responsibilities Policy *This requirement is found in the Member Rights and Responsibilities Policy (page 2). While CCHA cannot control the actions of HCPF, CCHA staff will always work with HCPF and the member to ensure the member's rights are being preserved and the member is not adversely impacted in any way due to exercising said rights.* https://www.cchacares.com/for-members/member-benefits-services/ https://www.cchacares.com/for-members/frequently-asked-questions/ *The CCHA website, via the Member Benefits and Services page and Member Frequently Asked Questions page, provides members with information regarding member rights and their ability to exercise said rights without retaliation. Additionally, CCHA provides a link to the Health First Colorado Member Handbook to learn more.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *Information regarding member rights is provided to physical health providers through the provider manual (pages 6-7).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *Information regarding member rights is provided to behavioral health providers through the provider manual (page 96).*	
5. The RAE complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.U	IV.MRP.1_CCHA_Member Rights and Responsibilities Policy *This requirement is addressed in CCHA's Member Rights and Responsibilities Policy (page 2).* IV.MRP.1_CCHA_ADA Compliance for Network Providers Policy *This document is CCHA's policy regarding the availability of network providers to meet the needs of members with disabilities (entire document), including access to language assistance and auxiliary aids for communication (page 2).* IV.MRP.1_CCHA_Member and Provider Materials and Website Policy *This CCHA policy contains reference to this requirement as language assistance is governed under state and federal laws (page 3).* IV.MRP.5_CCHA_BH Provider Agreement Template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA's contracted behavioral health providers are informed of RAE and provider responsibilities to abide by these regulatory requirements through the behavioral health provider contract (page 20). CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *CCHA's contracted physical health providers are informed of RAE and provider responsibilities to abide by these regulatory requirements through the physical health provider manual (page 13).*	
6. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: 20.A Exhibit A—2.c and 3.a	IV.MRP.1_CCHA_Privacy Policy *CCHA's Privacy Policy demonstrates compliance with this requirement by outlining CCHA's policies regarding member privacy and member PHI, including the confidentiality of patient information (page 3), the use and disclosure of member PHI where authorization is not required (page 5), and the use and disclosure of member PHI where authorization is required (page 6).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. • The difference between institutionwide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated.	IV.MRP.7_CCHA_Advance Directives Policy *This document is CCHA's policy and procedure regarding advance directives that covers CCHA's responsibilities towards its members, providers, staff, and community partner, and it contains all of the requirements required by the contract and federal regulation (entire document).* IV.MRP.7_Prog Description - CCHA Complex Care Management *CCHA's care coordinators provide education to members and their families about advance directive options and tools, when appropriate. This document is provided as an example of how advance directives are promoted in CCHA's care coordination model (page 9).* CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *Information regarding advance directives is provided to physical health providers via the provider manual (page 10).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *Information regarding advance directives is provided to behavioral health providers via the provider manual (page 88).* IV.MRP.7_CCHA_Advance Care Planning Resources_ENG IV.MRP.7_CCHA_Advance Care Planning Resources_SPAN *This document serves as a resource guide for members and provides information on how CCHA can support advance care planning and is available in English and Spanish.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives. • Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment.	https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook *The Health First Colorado member handbook contains useful information regarding advance directives. We link to the handbook from the CCHA website and refer members to the member handbook.* https://www.cchacares.com/for-members/frequently-asked-questions/ *The CCHA website includes frequently asked questions and a link to an advanced planning resource for members.* https://m.x-plain.com/HealthEncyclopedia/HEesk_CCHA.php?key=cchahe201712&c=GJy7mJyW3iw8ta679gpgvkCnEaQ33lgXjACsgZElQ44&m=ad010106&l=1&a=advance *CCHA's Health Topic Library contains member facing information regarding advance directives.*	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.1.3–7		

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

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 1: Exhibit B1—7.2.5, 7.3.6.1	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This document outlines the language and accessibility requirements as it relates to member materials (page 1), including CCHA's requirement for member testing and its definition of large-scale communications (page 3).*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit B1—7.3.6.1	https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook *The Health First Colorado website contains valuable information for members regarding their benefits under Medicaid and any cost sharing requirements.* https://www.cchacares.com/for-members/member-benefits-services/ *The CCHA website contains information about the benefits and services CCHA provides.* https://www.cchacares.com/media/1140/ccha__member_guide_rae_2018_oo.pdf *This document, which is also provided to members as a printed document, outlines the services CCHA provides to members and how to access services.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.cchacares.com/for-members/frequently-asked-questions/ *Contains frequently asked questions for members about benefits, services and requirements of the plan.*	
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices.	V.MI.1_CCHA_Member and Provider Materials and Website Policy *Even though this requirement is N/A; CCHA has included this requirement in its Member & Provider Materials & Website P&P to ensure compliance with federal and contractual requirements (pages 1-2).*	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(c)(4) Contract Amendment 1: Exhibit B1—3.6, 7.3.4		
Findings: The Department has not provided a list of these definitions to the RAEs, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the RAE to be aware of this requirement and to consistently use definitions from the Department when available.		
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18-point) and prevalent non-English	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This document contains all information from this requirement (page 2), including the definition of the prevalent non-English languages that are present in CCHA's service regions.* https://www.cchacares.com/ *All member-facing pages found under About CCHA and For Our Members includes instructions on how to receive information in alternative formats. Additionally, CCHA links to the Health First Colorado Member Handbook via the Member Benefits and Services page, and Member FAQ page.* https://www.cchacares.com/for-members/find-a-provider/ *This is a link to our online provider directory where members can export a paper version of the directory, as well as information on how to request a paper version from Member Support Services.* V.MI.4_CCHA_Provider Search Guide *CCHA developed this reference guide to train staff, and some community partners, on how to use the online CCHA Provider Search.* V.MI.4_Member Complaint Acknowledgement Letter ENG	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit B1—7.2.7.3–9; 7.3.13.3	V.MI.4_Member Complaint Acknowledgement Letter SP *This document is sent to a member acknowledging their grievance, which complies with all information requirements.* V.MI.4_Member Complaint Resolution Letter ENG V.MI.4_Member Complaint Resolution Letter SP *This document is the letter sent to a member informing them of their grievance resolution, which complies with all information requirements.* V.MI.4_CO AG Appeal Dismiss Letter ENG V.MI.4_CO AG Appeal Dismiss Letter SP *This document is sent to a member informing them of their appeal being dismissed, which complies with all language requirements.* V.MI.4_CO AG Appeal Past Timely Filing Ltr ENG V.MI.4_CO AG Appeal Past Timely Filing Ltr SP *This document is sent to a member when their appeal is filed outside of the 60 calendar day window as communicated on the Notice of Adverse Benefit Determination, which complies with all language requirements.* V.MI.4_CO UM Retro Adverse Action Letter ENG V.MI.4_CO UM Retro Adverse Action SP *This document is sent to a member when CCHA denies payment for a service, which complies with all language requirements.* V.MI.4_CO UM Denial Letter ENG V.MI.4_CO UM Denial Letter SP	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document is sent to a member when a request for service is denied, which complies with all language requirements. V.MI.4_CO BH Denial Letter with CvrSheet ENG V.MI.4_CO BH Denial Letter with CvrSheet SP *This document is the CCHA specific version of the state developed Notice of Adverse Benefit Determination that is sent to a member when CCHA makes an adverse benefit determination, which complies with all language requirements.* V.MI.4_CO AG Appeal Ack Ltr-Verbal ENG V.MI.4_CO AG Appeal Ack Ltr-Verbal SP *This document is sent to acknowledge a member's verbal appeal and request their written consent, which complies with all language requirements.* V.MI.4_CO AG Appeal Ack Letter-Written ENG V.MI.4_CO AG Appeal Ack Letter-Written SP *This document is sent to acknowledge a member's written appeal, which complies with all language requirements.* V.MI.4_CO AG Appeal Admin Uphold Ltr ENG V.MI.4_CO AG Appeal Admin Uphold Ltr SP *This document is used to inform a member that CCHA's original appeal decision was upheld, which complies with all language requirements.* V.MI.4_CO AG Appeal Internal Rights Exhausted ENG V.MI.4_CO AG Appeal Internal Rights Exhausted SP	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document informs a member that they have exhausted their internal appeal rights with CCHA, which complies with all language requirements. V.MI.4_CO AG Appeal Medical Necessity Uphold Ltr ENG V.MI.4_CO AG Appeal Medical Necessity Uphold Ltr SP *This document informs a member that CCHA's original appeal decision was upheld due to medical necessity, which complies with all language requirements.* V.MI.4_CO AG Appeal Overturn Ltr ENG V.MI.4_CO AG Appeal Overturn Ltr SP *This document informs a member that CCHA has overturned their original appeal decision, which complies with all language requirements.* V.MI.4_CO AG Appeal Time Frame Ext Notif Ltr ENG V.MI.4_CO AG Appeal Time Frame Ext Notif Ltr SP *This document acknowledges the conversation to extend a member's appeal timeframe, which complies with all language requirements.* V.MI.4_CO AG Appeal Withdrawal Ltr ENG V.MI.4_CO AG Appeal Withdrawal Ltr SP *This document informs a member that their appeal request has been withdrawn, which complies with all language requirements.*	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This document contains the requirements for member information made available electronically (page 4).* *https://www.cchacares.com/* *All member-facing pages on the CCHA website, under About CCHA and For Members, includes instructions on how to receive information in alternative formats.* https://www.cchacares.com/for-members/member-benefits-services/ *Information regarding the member's ability to request a paper version of the provider directory to be mailed within five business days free of charge is found on this page.*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: HSAG evaluated CCHA's website, cchacares.com, using the WAVE accessibility tool and found that a sample of webpages contained accessibility and contrast errors.		
Required Actions: CCHA must ensure that its website is fully readily accessible per Section 508 guidelines.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: Exhibit B1—None	https://www.cchacares.com/for-members/frequently-asked-questions/ *The link to member FAQs on the CCHA website complies with this requirement, as it contains information for members on where to find the HCPF formulary. CCHA does not produce its own formulary as it does not manage the prescription drug benefit.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The RAE makes interpretation services (for all non-English languages) available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The RAE notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and informs how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit B1—7.2.6.2–4	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This CCHA policy outlines CCHA's requirements as related to oral interpretation services and availability of written translation (pages 2-3).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *Information regarding interpretation services is provided to behavioral health providers via the provider manual (page 9).* CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *Information regarding interpretation services is provided to physical health providers via the provider manual (page 8).* https://www.cchacares.com/for-members/frequently-asked-questions/ *Frequently asked questions informing members they have access to oral interpretation services.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	How to guides: V.MI.7_CCHA Translation Services Procedure V.MI.7_(CyraCom) VRI User Quick Start Guide V.MI.7_(CyraCom) App Quick Start Half Sheet *These documents outline the process of requesting translation services.*	
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit B1—7.2.6.1, 7.2.6.5	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This document addresses CCHA's policy to ensure language assistance is provided to members (page 2).*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit B1--None	N/A, CCHA does not produce a member handbook.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: CCHA did not produce or distribute its own member handbook.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 1: Exhibit B1--None	N/A, CCHA does not produce a member handbook.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: CCHA did not produce or distribute its own member handbook.		
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 1: Exhibit B1—7.3.8.1	N/A, CCHA does not produce a member handbook. https://www.cchacares.com/ *CCHA links to the Health First Colorado Member Handbook via the CCHA website, specifically the Member Benefits and Services page, and Member FAQ page.*	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: CCHA did not produce or distribute its own member handbook or a supplement to the Department's Health First Colorado Member Handbook.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 1: Exhibit B1—7.3.10.1	V.MI.12_CCHA_Notification of Practice Termination or Closure Policy *This document outlines CCHA's policy regarding the notification of members when a provider or practice leaves the network (page 2).* V.MI.12_CCHA_Practice Closing Procedure *This document outlines the process for notifying members of when a PCMP or physical health practice closes or terminates their agreement with CCHA (page 1).* V.MI.12_CCHA_PCMP Termination Procedure *This document outlines the process for notifying members of when a PCMP is terminated from the CCHA network for cause (page 2).* V.MI.12_CCHA_Behavioral Health Provider Termination Letter Procedure *This is the desk procedure outlining the steps to send out the behavioral health provider termination notification letter to impacted members.* V.MI.12_CCHA_Practice Closure Template (already closed)_ENG V.MI.12_CCHA_Practice Closure Template (already closed)_SP *This is a sample version of the letter that is sent to members when their PCMP or physical health practice has left the CCHA network, available in English and Spanish.* V.MI.12_CCHA_Practice Closure Template (announcing closure)_ENG V.MI.12_CCHA_Practice Closure Template (announcing closure)_SP	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This is a sample version of the letter that is sent to members when their PCMP or physical health practice is closing or leaving CCHA's network, available in English and Spanish. V.MI.12_CO OP Behavioral Health Termination Letter-ENG V.MI.12_CO OP Behavioral Health Termination Letter-SP *This document is sent to members when their behavioral health provider leaves the CCHA network, available in English and Spanish.*	
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit B1—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This document outlines CCHA's website requirements (page 4).* • RAE's contact information https://www.cchacares.com/about-ccha/contact-us/ https://www.cchacares.com/for-members/important-contact-info/ • Member rights and handbooks https://www.cchacares.com/for-members/member-benefits-services/ https://www.cchacares.com/for-members/frequently-asked-questions/ • Grievance and appeal procedures and rights https://www.cchacares.com/for-members/member-benefits-services/ https://www.cchacares.com/for-members/frequently-asked-questions/ • General functions of the RAE	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.cchacares.com/for-members/member-benefits-services/ https://www.cchacares.com/about-ccha/overview-structure/ • Trainings For providers: https://www.cchacares.com/for-providers/provider-resources-training/ For members: https://m.x-plain.com/HealthEncyclopedia/HEesk_CCHA.php?c=GJy7mJyW3iw8ta679gpgvkCnEaQ33lgXjACsgZElQ44&key=cchahe201712 • Provider directory https://www.cchacares.com/for-members/find-a-provider/ • Access to care standards https://www.cchacares.com/for-members/frequently-asked-questions/ • Health First Colorado Nurse Advice Line https://www.cchacares.com/for-members/important-contact-info/ https://www.cchacares.com/for-members/frequently-asked-questions/ • Colorado Crisis Services information https://www.cchacares.com/for-members/important-contact-info/	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.cchacares.com/for-members/frequently-asked-questions/ • A link to the Department's website for standardized information such as member rights and handbooks https://www.cchacares.com/for-members/member-benefits-services/ https://www.cchacares.com/for-members/frequently-asked-questions/	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical	https://www.cchacares.com/for-members/find-a-provider/ *Per the link above, CCHA's Provider Directory is updated daily. The directory contains the following information on contracted Network Providers:* • *Whether the provider is accepting new patients,* • *Provider or practice type (search by specialty),* • *The name and practice name, street address, telephone number, website (if available);* • *Languages spoken and whether the provider has completed cultural competency training; and,* • *Whether the provider's office has accommodations for members with disabilities.* *If a member would like a paper version of the directory or the directory in a different format, they can download and print a copy using the search function. Likewise, they can call CCHA Member Support Services and a paper version will be provided free of charge upon request.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit B1—7.3.9.1.6	*For all other provider types, CCHA links to the HCPF provider directory, as we are only required to report out on our contracted provider types (see HSAG Audit Question document for reference).*	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	https://www.cchacares.com/for-members/find-a-provider/ *The CCHA provider directory can be exported into CSV, Excel, and PDF formats, with the option to copy or print.*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: HSAG evaluated CCHA's website, cchacares.com, for machine-readability using the WAVE Web accessibility evaluation tool and found that the searchable provider directory had significant accessibility and contrast errors.		
Required Actions: CCHA must ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.		
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • RAE's single toll-free customer service phone number. • RAE's email address.	V.MI.16_CCHA_Map_to_Medicaid_ENG V.MI.16_CCHA_Map_to_Medicaid_SP *This document serves as a CCHA member guide for Health First Colorado members, and includes information on how to contact CCHA and Health First Colorado benefits and services. It is available in both English and Spanish.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

• RAE's website address.
• State relay information.
• The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP).
• Which populations are subject to mandatory enrollment into the Accountable Care Collaborative.
• The service area covered by the RAE.
• Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit.
• Any restrictions on the member's freedom of choice among network providers.
• The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards.
• The RAE's responsibilities for coordination of member care.
• Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections.
• To the extent possible, quality and performance indicators for the RAE, including member satisfaction.
	V.MI.16_CCHA_CC_Insert_ENG_and_SP
	This insert provides information for members regarding CCHA's care coordination services. It is available in both English and Spanish.
	
	V.MI.16_CCHA_Dental_Benefits_ENG and SP_R6
	This insert describes Health First Colorado dental benefits in detail in both English and Spanish.
	
	V.MI.16_CCHA_ER_Handout_November_2018_ENG
	V.MI.16_CCHA_ER_Handout_November_2018_SP
	This document provides members with contact information for CCHA, Health First Colorado Nurse Advice Line, and Colorado Crisis Services. It is available in both English and Spanish.
	
	V.MI.16_CCHA_Transportation_Insert_ENG and SP
	This flyer is used to inform members they can request assistance with transportation, and includes both English and Spanish.
	
	V.MI.16_CCHA_BH Reference Guide_ENG
	V.MI.16 CCHA_BH Reference Guide_SP
	This document for members serves as a quick reference guide to behavioral health. It is available in both English and Spanish.
	
	CCHA's single toll-free customer service phone number is listed on:
	• CCHA website Contact Us page
	• All member facing print materials including:
	  ○ V.MI.16_CCHA_Map_to_Medicaid_ENG
	  ○ V.MI.16_CCHA_BH Reference Guide_ENG	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 1: Exhibit B1—7.3.6.1	○ V.MI.16_CCHA_ER_Handout_November_2018_ENG • All member correspondence CCHA's email address can be found on: • CCHA website Contact Us page • Contact Us Form CCHA's website address can be found on: • All member facing print materials including: ○ V.MI.16_CCHA_Map_to_Medicaid_ENG ○ V.MI.16_CCHA_BH Reference Guide_ENG ○ V.MI.16_CCHA_ER_Handout_November_2018_ENG • All member correspondence CCHA includes State relay information on: • CCHA website Contact Us page • All member facing print materials including: ○ V.MI.16_CCHA_Map_to_Medicaid_ENG ○ V.MI.16_CCHA_BH Reference Guide_ENG ○ V.MI.16_CCHA_ER_Handout_November_2018_ENG • All member correspondence The basic features of CCHA's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP) • CCHA website Member Benefits & Services page • CCHA website Connect with a Care Coordinator page	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

	• CCHA website Frequently Asked Questions page
	• Member facing print materials including:
	  ○ V.MI.16_CCHA_Map_to_Medicaid_ENG
	  ○ V.MI.16_CCHA_BH Reference Guide_ENG
	
	Which populations are subject to mandatory enrollment into the Accountable Care Collaborative is located on:
	• CCHA Website Member Frequently Asked Questions page
	
	The service area covered by CCHA is included on:
	• CCHA website About Us
	• CCHA website Member Benefits & Services page
	• CCHA website Member Frequently Asked Questions page
	• Member facing print materials including:
	  ○ V.MI.16_CCHA_Map_to_Medicaid_ENG
	  ○ V.MI.16_CCHA_BH Reference Guide_ENG
	
	Information on Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit can be found on:
	• CCHA website Member Benefits & Services page, link to HealthFirstColorado.com description
	• CCHA website Member Frequently Asked Questions page
	• Member facing print materials including:
	  ○ V.MI.16_CCHA_Map_to_Medicaid_ENG
	  ○ V.MI.16_CCHA_BH Reference Guide_ENG
	
	Any restrictions on the member's freedom of choice among network providers.
	• Not applicable. CCHA does not restrict member’s choice of provider.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Refer to CCHA's Member Rights and Protections policy and the CCHA website Frequently Asked Questions page. The requirement for CCHA to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards, is included on: • CCHA website Member Frequently Asked Questions page Information on CCHA's responsibilities for coordination of member care can be found on: • CCHA website About Us • CCHA website Member Benefits & Services page • CCHA website Member Frequently Asked Questions page • Member facing print materials including: o V.MI.16_CCHA_Map_to_Medicaid_ENG o V.MI.16_CCHA_BH Reference Guide_ENG Information about where and how to obtain counseling and referral services that CCHA does not cover because of moral or religious objections • CCHA website Frequently Asked Questions https://www.cchacares.com/about-ccha/advisory-committees/meeting-minutes/ • *CCHA shared Key Performance Indicator (KPI) data with the regional Program Improvement Advisory Committee (PIAC) in Q3. Meeting minutes are provided above.* • *Behavioral Health Incentive measures are calculated by HCPF once per year, and will be made available at that time.*	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *CAHPS and ECHO survey data will be made available to providers and members as appropriate, after year one results are released.*	
17. The RAE will annually mail each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit B1—7.3.8.1	N/A *On March 21, 2019, the Department issued a Policy Transmittal (document titled V.MI.17_RAE 19-03 Member Handbook Notification Policy) removing from contract the requirement for the RAE to mail each member a notice of how to request a copy of the handbook, effective July 1, 2019.* *Per communication from HCPF on 3/19/2019 (document titled V.MI.17_Review Requested CCHA Contract Amendments), this requirement will not be subject to audit.*	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: Communication from the Department indicated that this requirement is no longer applicable to the RAEs.		
18. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided	V.MI.1_CCHA_Member and Provider Materials and Website Policy *This document outlines CCHA's policy for providing information to members, as included in this requirement (page 2). Once a member provides their consent to have information submitted electronically, this is noted in Essette for future reference.* V.MI.18_CCHA_Form_Auth to Release PHI_Transmit PHI_FINAL_090717 *This document requests consent from a member to view or access personal health information (PHI), which includes consent for email communications. This consent is documented in CCHA's care coordination tool and the release is uploaded.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit B1—None		
19. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit B1—None	https://www.cchacares.com/for-members/frequently-asked-questions/ *This page on the CCHA website informs members of their right to request any physician incentive plans in place by contacting Member Support Services.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard V—Member Information							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	5	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	86%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. Contract Amendment 1: Exhibit B1—7.3.12.1	XI.EPSDT.1_CCHA_EPSDT Policy *This document outlines CCHA's policy and procedure related to EPSDT, which includes providing information to members and their families regarding EPSDT benefits, and how to obtain additional information (page 4-5).* XI.EPSDT.1_Prog Description _ CCHA Pediatric_Foster Care *CCHA's care coordination program description outlining care coordination activities for pediatric and foster care populations, including activities to inform the member and their families regarding EPSDT benefits (page 8).* XI.EPSDT.1_Family Friendly Version of EPSDT Regulations *CCHA leverages HCPF's materials, and distributes this EPSDT handout to members engaged in care coordination, and to community partners (entire document).* https://www.cchacares.com/for-members/frequently-asked-questions/ *Information on CCHA's website to inform members and their families of EPSDT benefits and address frequently asked questions.*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information: • The RAE employs Department materials to inform network providers about the benefits of well-child care and EPSDT.	CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *CCHA's Physical Health Provider Manual includes information on EPSDT benefits, and informs providers of training materials made available through HCPF (page 8-9).*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The RAE ensures that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 1: Exhibit B1—7.6.2.3, 12.8.3.4; 12.9.3.4	XI.EPSDT.2_CCHA Provider Newsletter_ March 2019 *This edition of CCHA's Provider Newsletter informed providers of the EPSDT benefit, and linked to HCPF resources for EPSDT educational materials. Additionally, the newsletter informed network providers of the upcoming Provider Town Hall meeting, in which CCHA distributed EPSDT materials. (page 4, section Training Opportunities)* XI.EPSDT.1_Family Friendly Version of EPSDT Regulations *CCHA leverages HCPF's materials, and distributes this EPSDT handout to members engaged in care coordination, and to community partners. (Entire document)* XI.EPSDT.2_CCHA Staff EPSDT Training Log R7 *CCHA collaborated with HCPF to host a training for CCHA care coordination and practice transformation coach staff. This is an attendee list from the training, held on November 14, 2018.* XI.EPSDT.2_CCHA Staff EPSDT Fact Sheet *Resulting from the EPSDT training, CCHA developed this fact sheet as a desk reference for care coordinators and practice transformation coaches. (entire document)* https://www.cchacares.com/for-providers/provider-resources-training/ *CCHA provides a link to HCPF's EPSDT page from the General Information and Resources Section of the CCHA website.*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE shall create an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE shall train Healthy Communities contractors about the Accountable Care Collaborative and the RAE's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	XI.EPSDT.3_Healthy Communities at El Paso County_CCHA_Health Neighborhood_MOU_1.23.19 *This MOU between CCHA and El Paso County Healthy Communities outlines goals for collaboration, roles and responsibilities, referral process, etc., for onboarding children and families.* XI.EPSDT.3_Park_County_Public_Health_CCHA_Health_Neighborhood_MOU_10.30.18 *This MOU between CCHA and Park County Healthy Communities outlines goals for collaboration, roles and responsibilities, referral process, etc., for onboarding children and families.* XI.EPSDT.3_Teller_County_Public_Health_and_Environment_CCHA_Health_Neighborhood_MOU_10.30.18 *This MOU between CCHA and Teller County Healthy Communities outlines goals for collaboration, roles and responsibilities, referral process, etc., for onboarding children and families.* XI.EPSDT.3_Teller HC Workflow XI.EPSDT.3_Park HC Workflow *Workflows have been established between the Healthy Communities contractors and CCHA to the outline process for collaboration to onboard children and families.* **Ongoing Collaboration** *CCHA has finalized MOUs with Healthy Communities entities in El Paso, Park, and Teller County. CCHA is engaged in ongoing*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	collaboration with healthy Communities to establish and refine workflow/referral processes, data exchange, identification of high-risk members, and partnership management. CCHA met with the Healthy Communities coordinators in El Paso County on 10/2, 10/10, 140/23, and 11/9; with Teller County on 10/5, 10/10, 10/22, and 3/11; and, Park County on 9/19, 10/3, 10/10, and 3/5.	
4. The RAE assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit B1—12.8.7.6	XI.EPSDT.1_CCHA_EPSDT Policy *This document outlines CCHA's policy and procedure related to EPSDT, which includes educating providers on EPSDT benefits and providing assistance in resolving barriers or problems related to accessing EPSDT services (page 5).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *CCHA's Behavioral Health Provider Manual outlines that CCHA provides assistance to providers in resolving barriers related to EPSDT benefits (page 100).* CCHA PH Provider Manual https://www.cchacares.com/media/1257/ccha_provider-manual_ph-pcp_2019-version_wip.pdf *CCHA's Physical Health Provider Manual includes information on EPSDT benefits, and informs providers that CCHA can assist in resolving barriers or problems related to EPSDT benefits (page 9).* XI.EPSDT.2_CCHA Provider Newsletter_ March 2019	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This edition of CCHA's Provider Newsletter informed providers of the EPSDT benefit, and linked to HCPF resources for EPSDT educational materials. Additionally, the newsletter informed network providers of the upcoming Provider Town Hall meeting, in which CCHA distributed EPSDT materials.	
5. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280. (EPSDT program). For the Capitated Behavioral Health Benefit, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screening to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions	XI.EPSDT.1_CCHA_EPSDT Policy *This document outlines CCHA's policy and procedure related to EPSDT, which includes the provision of all medically necessary behavioral health services for children under the age of 21 in accordance with the EPSDT program and 42 CFR Sections 441.50 to 441/62 and 10 CCR 2505-10 8.280 (page 3).* XI.EPSDT.1_Prog Description – CCHA Pediatric_Foster Care *CCHA's care coordination program description outlines care coordination activities for pediatric and foster care populations, including that care coordinators will assist in arranging for the provision of all medical necessary behavioral health services, and supports the member in accessing appropriate mental/behavioral health screening though qualified providers and in a manner that is culturally and linguistically sensitive to the member (page 8). Additionally, activities are documented in CCHA's electronic care coordination tool (page 9).*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
Findings: CCHA's EPSDT policy addressed verbatim all requirements for provision of medically necessary behavioral health services for EPSDT-eligible members. In addition, CCHA demonstrated that it arranges for provision of all necessary services for members referred to pediatric care coordination. CCHA's behavioral health (BH) provider manual addressed requirements for all services not specific to EPSDT to be performed by qualified mental health professionals, in a culturally competent manner, and documented in the medical record. However, neither the BH provider manual nor other provider communications clearly documented the responsibilities of BH providers for provision of all required components of the capitated behavioral health benefits related to EPSDT, specifically—"provision of all appropriate mental/behavioral health developmental screening" and "provision of diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure." In addition, HSAG observed that the BH provider manual did not address any expected relationship between primary care and behavioral health providers to ensure provision of needed EPSDT screenings and services; therefore, HSAG recommends that CCHA consider opportunities to do so.		
Required Actions: CCHA must enhance provider communications to ensure that BH providers understand all requirements for the provision of applicable EPSDT-related capitated behavioral health services for members ages 20 and under.		
6. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family.	XI.EPSDT.6_CCHA Community Resources Referred Assessment *This assessment is completed by care coordination and identifies member needs and referrals including transportation and social services such as WIC, SNAP, TAN, etc. (page 3).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61-62* Contract Amendment 1: Exhibit B1—14.5.3	*CCHA's Behavioral Health Provider Manual outlines that CCHA provides referral assistance, assistance with transportation, and makes use of other state health agencies and programs (page 100).* XI.EPSDT.6_CCHA_Map_to_Medicaid_ENG XI.EPSDT.6_CCHA_Map_to_Medicaid_SP *This document serves as a CCHA member guide for Health First Colorado members, and includes information on how to contact CCHA and Health First Colorado benefits and services. Additionally, this document outlines that CCHA refers members to other social service programs, and provides assistance with transportation, as needed (entire document).* XI.EPSDT.6_CCHA_BH Reference Guide_ENG XI.EPSDT.6_CCHA_BH Reference Guide_SP *This document for members serves as a quick reference guide to behavioral health and is available in both English and Spanish.* XI.EPSDT.1_Prog Description – CCHA Pediatric_Foster Care *CCHA's care coordination program description outlining care coordination activities for pediatric and foster care populations, including that CCHA provides referral and transportation assistance, as needed (page 8).*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	XI.EPSDT.1_CCHA_EPSDT Policy *This document outlines CCHA's policy and procedure related to EPSDT, which includes the definition of medical necessity for EPSDT services (page 2).* CCHA BH Provider Manual https://www.cchacares.com/media/1225/aco-pm-0004-19-colorado-bh-provider-manual-update-final-with-cover.pdf *CCHA's Behavioral Health Provider Manual includes the definition of EPSDT medical necessity (page 101).*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: CCHA's EPSDT policy and BH provider manual defined verbatim the components of the definition of medical necessity for EPSDT services. However, CCHA's *Clinical Criteria for Utilization Management Decisions* policy and procedure defined "medical necessity" using language that did not correspond to the most recent version of medical necessity criteria outlined in the Colorado Code of Regulations—10 CCR 2505-10–8.076.8, 8.076.8.1, and 8.280.4.E.—including the EPSDT-specific medical necessity criteria. As such, it appeared that some medical necessity criteria important to authorization of EPSDT-related capitated BH services may have been omitted, including those noted in bold below: • 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 delivered in the most appropriate settings required by the client's condition.*** • ***Provides a safe environment or situation for the child.***		
Required Actions: CCHA must ensure that medical necessity criteria for utilization management decisions pertaining to EPSDT-related services are consistent with CCHA's EPSDT policy and correspond with the complete definition of "medical necessity" outlined in 10 CCR 2505-10–8.076.8, 8.076.8.1, and 8.280.4.E.		
8. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities; clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 1: Exhibit B1—14.5.8.1	XI.EPSDT.1_CCHA_EPSDT Policy *This document outlines CCHA's policy and procedure related to EPSDT, which includes the arrangement of vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services and respite services (page 4).* XI.EPSDT.1_Prog Description – CCHA Pediatric_Foster Care *CCHA's care coordination program description outlining care coordination activities for pediatric and foster care populations, including that CCHA provides or arranges for vocational services, intensive case management, prevention/early intervention activities,*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services and respite services (page 8). XI.EPSDT.6_CCHA Community Resources Referred Assessment *This assessment is completed by care coordination to identify member needs including vocational services, and outlines referrals to behavioral health services (entire document).* XI.EPSDT.8_The Resource Exchange_CCHA_Health Neighborhood MOU_11.28.18 *This MOU outlines CCHA's collaboration with the local Community Centered Board agency, which includes roles and responsibilities, referral process and identifies a single point of contact for members who may be utilizing the aforementioned Capitated Behavioral Health benefits.* XI.EPSDT.8_190306_AspenPointe Meeting Minutes_Final *CCHA utilizes several platforms for collaboration to review cases and determine other services needed to support the member and ensure they are connected to the right services at the right time. Such platforms include: daily integrated rounds, collaborative management meetings, creative solutions calls with HCPF, ongoing and ad hoc meetings with county Department of Human Services (DHS), Community Mental Health Centers (CMHCs), Single Entry Points (SEPs) and Community Centered Boards (CCBs). Descriptions of a few platforms are provided below.*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Daily integrated rounds are regularly attended by the CCHA's Chief Clinical Officer utilization reviewers, and Care Coordinators. Caseworkers from the appropriate Department of Human Services and Community Mental Health Center are invited to attend as needed, and as permitted under HIPAA. Daily integrated rounds provide a platform to discuss challenging cases and for cross disciplinary teams to work together to develop treatment plans for members which include providing for and arranging EPSDT services and/or b3 services such as respite, assertive community treatment, residential treatment, and intensive case management. *Additionally, CCHA's Chief Clinical Officer, attends regular treatment team meetings at Jefferson Center for Mental Health where clinical staff bring challenging cases for discussion and treatment planning as described above. CCHA plans to expand daily integrated rounds to include a greater number of community entities and other service providers to review cases and ensure services are being coordinated effectively.* *Additionally, CCHA has been actively collaborating with CMHCs, SEPs, CCBs and county DHS to establish workflows and processes to streamline services for members, specifically those being discharged from a hospital, in order to avoid duplication and strengthen coordination of services. These processes allow CCHA and community partners to identify additional services needed to ensure the most positive outcome and experience for the member. Some of those services include: intensive case management, residential care, assertive community treatment, respite services, and other outpatient services. See sample meeting minutes attached.*	

Results for Standard XI—EPSDT Services							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	6
			Total Score ÷ Total Applicable			=	75%

Appendix B. Record Review Tools

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

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **CCHA R7**.

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

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Gina Stepuncik	Senior Project Manager
Dara Dameron	Project Manager
CCHA R7 Participants	**Title**
Abby Lisowski	Director, Client Services
Adrian Sovik	Regional Director
Amanda Mrkvicka	Supervisor, Pediatric Team
Amy Moore	Lead, Behavioral Health Care Coordinator
Amy Yutzy	Director, Medicaid Programs
Colleen Daywart	Manager, Communications
Danielle Johnson	Care Coordinator, Behavioral Health
Deb Munley	Vice President, Clinical Programs
Elizabeth Holden	Director, Behavioral Health Quality
Eric Shcreibor	Social Worker, Physical Health Care Coordinator
Hanna Thomas	Director, Medicaid Programs
Heather Piernik	Director, Behavioral Health
Janet Pogar	Regional Vice President, Provider Solutions
Jillian Rivera	Peer Support
Kate Stingl	Care Coordinator, Behavioral Health
Ken Nielsen	Executive Director, Board Member
Kim Cassidy	Manager, Behavioral Health Care Coordinator
Krista Newton	Director, Care Coordination
Lisa Lockwood	Care Coordinator, Pediatric Behavioral Health
Melissa Espinoza	Peer Support
Michelle Blady	Lead Care Coordinator, Behavioral Health
Nikole Mateyka	Supervisor, Care Coordinator
Norma Cameron	Care Coordinator, Physical Health
Sarah Rose Quintana	Director, Care Coordination

CCHA R7 Participants	Title
Sheryl Slankard	Care Coordinator
Sophie Thomas	Program Manager, Medicaid
Terri Ridgeway	Supervisor, Clinical Programs
Toni Barkley	Care Coordinator, Behavioral Health
Tony Olimpio	Manager, Member Services
Zula Solomon	Director, Quality Population Health
Department Observers	**Title**
Amanuel Melles	Program Administrator
Morgan Anderson	Program Specialist
Murielle Romine	Program Administrator
Russell Kennedy	Quality Compliance Specialist
Lauren Ambrozic	Medical Cost Control Manager
Gina Robinson	EPSDT Program Administrator

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

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for CCHA R7

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	HSAG evaluated CCHA's website, cchacares.com, using the WAVE accessibility tool and found that a sample of webpages contained accessibility and contrast errors.	CCHA must ensure that its website is fully readily accessible per Section 508 guidelines.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information		
Requirement	**Findings**	**Required Action**
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	HSAG evaluated CCHA's website, cchacares.com, for machine-readability using the WAVE Web accessibility evaluation tool and found that the searchable provider directory had significant accessibility and contrast errors.	CCHA must ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.
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 XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
5. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280. (EPSDT program). For the Capitated Behavioral Health Benefit, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screening to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)*	CCHA's EPSDT policy addressed verbatim all requirements for provision of medically necessary behavioral health services for EPSDT-eligible members. In addition, CCHA demonstrated that it arranges for provision of all necessary services for members referred to pediatric care coordination. CCHA's behavioral health (BH) provider manual addressed requirements for all services--not specific to EPSDT-- to be performed by qualified mental health professionals, in a culturally competent manner, and documented in the medical record. However, neither the BH provider manual nor other provider communications clearly documented the responsibilities of BH providers for provision of all required components of the capitated behavioral health benefits related to EPSDT, specifically—"provision of all appropriate mental/behavioral health developmental screening" and "provision of diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure."	CCHA must enhance provider communications to ensure that BH providers understand all requirements for the provision of applicable EPSDT-related capitated behavioral health services for members ages 20 and under.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)		
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 XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
7. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational.	CCHA's EPSDT policy and BH provider manual defined verbatim the components of the definition of medical necessity for EPSDT services. However, CCHA's *Clinical Criteria for Utilization Management Decisions* policy and procedure defined "medical necessity" using language that did not correspond to the most recent version of medical necessity criteria outlined in the Colorado Code of Regulations—10 CCR 2505-10–8.076.8, 8.076.8.1, and 8.280.4.E.—including the EPSDT-specific medical necessity criteria. As such, it appeared that some medical necessity criteria important to authorization of EPSDT-related capitated BH services may have been omitted, including those noted in bold below: • 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 delivered in the most appropriate settings required by the client's condition.*** • ***Provides a safe environment or situation for the child.***	CCHA must ensure that medical necessity criteria for utilization management decisions pertaining to EPSDT-related services are consistent with CCHA's EPSDT policy and correspond with the complete definition of "medical necessity" outlined in 10 CCR 2505-10–8.076.8, 8.076.8.1, and 8.280.4.E.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
• Is not more costly than other equally effective treatment options. Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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

Appendix F. Focus Topic Discussion

Overview of FY 2018–2019 Focus Topic Discussion

For the FY 2018–2019 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE*. Focus topic interviews were designed to emphasize the member-related and provider-related components of transition and integration, including successes and challenges experienced in this inaugural year of RAE operations. HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the 2018–2019 RAE Aggregate Report to determine and document statewide trends related to the ACC objective of integrating behavioral and physical healthcare for members. This section of the report contains the interview guide and a summary of the focus topic discussion for **CCHA R7**.

Members

Transitioning Members Into the RAE and Continuity of Care

As the RAE contractor, **CCHA** was new to Region 7, with no previous relationship with either the Behavioral Health Organization (BHO) or Regional Care Collaborative Organization (RCCO) in Region 7. During the start-up period prior to implementation, **CCHA** hired the chief operating officer of the RCCO in Region 7 to lead the **CCHA** RAE in Region 7, thereby preserving continuity of relationships with the previous RCCO and many community partner agencies and providers. **CCHA** worked with the RCCO to identify a list of members with high-risk physical health needs, which totaled 750 members. **CCHA**'s Member Support Services team outreached to all individual members on the high-risk list to explain the RAE, ensure members that benefits would not change, and offer CC services to ensure continuity of care for members. **CCHA** Member Support Services staff made three contact attempts with each high-risk member, followed by an explanatory letter to those members who could not be contacted.

CCHA was stymied in its attempt to identify BH members engaged in or high-risk for behavioral health services. **CCHA** was unable to obtain from the BHO or CMHC a list of members engaged in BH services at the time of RAE implementation. In addition, **CCHA** had no source of previous BH claims data to identify members receiving services at the time of transition to the RAE. **CCHA** operationalized the Colorado Overutilization Program (COUP) lists from the Department to outreach to members through interactive voice response (IVR) calls to identify members needing continuity of care services. **CCHA** identified BH inpatient treatment providers and quickly developed relationships with those providers to continue payment for previously authorized BHO services and to identify members for CC. **CCHA** developed assessment processes and scripting of messaging for Member Support Services staff and care coordinators interacting with members and providers to explain the RAE transition. (Staff

members stated that no one in the region understood or related to the term "BHO"). **CCHA** transferred the local phone number for the RCCO call center to the RAE, as the RCCO call center was heavily utilized by members. Staff members also described that the highly locally-oriented population and provider dynamics of the region required that **CCHA** maintain a local contact number.

While **CCHA** attempted to use all available resources to identify and contact BH members during transition to the RAE, **CCHA** was unsure of whether or not continuity of care for some BH members was disrupted during the transition process. In addition to member identification issues, provision of previously established co-located BH services in numerous PCMP locations was initially discontinued, potentially disrupting BH services to those members. However, staff members stated that despite provider confusion regarding reimbursement for co-located BH services, most BH providers continued ongoing services being provided to individual members.

Major issues encountered in transitioning members into the RAE were related to the RAE attribution methodology, which resulted in confusion for both members and providers. Initially, the Department's letters to Medicaid members informing them of the change to the RAE and PCMP attribution confused members. **CCHA** used its website, stakeholder communications, and information provided to members through various member high-touch points—e.g., Marion House Soup Kitchen, Park and Teller county navigation partners, SEPs, and CCBs—to explain the meaning of the letter from HFC. While Region 7 experienced few cross-regional issues related to PCMP attribution, system-level issues with the attribution methodology resulted in a variety of intra-regional concerns. Most significantly, prior to RAE implementation, approximately 40 percent of members in the Region 7 RCCO were unattributed. When these members were attributed to PCMPs on implementation of the RAE, the Department's attribution methodology failed to incorporate PCMPs' Medicaid panel limits. This oversight resulted in a high number of previously unattributed members being assigned to PCMPs with established limits on panel size and lack of capacity to absorb newly attributed members. **CCHA** worked with the Department for reattribution of members due to system-level issues. **CCHA** noted that additional attribution issues were associated with specialized member populations as follows:

- Member Support Services received many calls from members engaged in services with a BH provider located in a region that did not coincide with the region to which the member had been attributed. Member Support Services developed messaging to ensure members that BH services could continue, and assisted members with reattribution when necessary.
- Foster care children in custody of DHSs in the region were assigned to PCMPs in Region 7 when placed in foster homes located in other regions. **CCHA** worked with the DHS case workers to proactively change attribution to a PCMP in the region associated with each member's placement home.
- The Department of Corrections (DOC) headquarters for the state is located in El Paso County. Many inmates in the criminal justice system were released to the DOC office address and attributed to PCMPs in El Paso County. However, these members could be residing in areas over a broad geographic area.
- Pediatric members were attributed to adult-only practices, as the Department's methodology for previously unattributed members assumed that "child follows family."

- Nursing home residents utilizing the PCMP associated with the nursing facility were reassigned to PCMPs geographically aligned with their residences.
- Members residing in Park County or Teller County, which have no or limited PCMP practices, were assigned to PCMPs in Colorado Springs—far from their homes. Whereas PCMPs in the perimeter areas of other regions, including Region 6, were geographically more accessible, these members were reattributed to those PCMPs.

In all cases, **CCHA** energized Member Support Services staff to assist members with re-attribution to appropriate providers through messaging, assisting with new PCMP selection, and conducting warm hand-off calls with the HFC enrollment broker. **CCHA**s practice transformation coaches trained providers to verify patient data in the Medicaid eligibility portal to identify whether members were correctly attributed to the PCMP and to assist individual members with reattribution when necessary. Providers could also refer a list of mis-attributed members to the **CCHA** Member Support Services staff, who outreached to all listed members to assist with reattribution to new PCMPs. For several months following RAE contract implementation, member attribution issues presented a significant challenge and workload for care coordinators and Member Support Services staff.

Care Coordination

Prior to implementation, **CCHA** hired all new care coordinators in Region 7 and conducted staff training regarding **CCHA**'s model of care coordination. In accordance with **CCHA**'s model of integrated care coordination teams, **CCHA** hired nurses, social workers, behavioral health specialists, and peer support specialists. Upon initiation of the RAE contract, **CCHA** worked with the RCCO to conduct a warm handoff to **CCHA** CCs of all members engaged in RCCO care coordination. In addition, Member Support Services outreaching to members on the RCCO's high-risk list identified that many of those members were not yet engaged in care coordination services; those members were referred to the **CCHA** CC team for follow-up.

CCHA designated Peak Vista and Mathews-Vu Medical Group as delegated CC entities and established an Accountable Care Network (ACN) contract with each, incorporating all CC requirements of the new RAE contract. Staff members stated that approximately 55 percent of all Region 7 members received services through the ACN providers. **CCHA** worked with the ACN providers early in RAE implementation to define CC workflows for BH members. **CCHA**'s Care Coordination team met with all regional PCMPs individually to explain **CCHA**'s CC model, which differed from the RCCO. **CCHA** also communicated the new CC model to PCMP and BH providers through provider town hall meetings.

CCHA maintained the CC processes previously implemented through the RCCO with criminal justice facilities. **CCHA** CC teams have experience with this population and have a specialized program team dedicated to criminal justice involved (CJI) members. **CCHA** recently hired for Region 7 a medical director with experience in the criminal justice system. Through these resources, **CCHA** will be able to further develop relationship with the DOC and processes for coordinating care for CJI members.

CCHA also maintained the RCCO's previously established relationships with Rocky Mountain Rural Health (Park County) and Aspen Mine Center (Teller County) to assist members in those counties with

navigation services and community resources. **CCHA** re-established a memorandum of understanding (MOU) with The Resource Exchange (CCB) to collaboratively coordinate services for children and adults with intellectual and developmental disabilities.

Providers

Transitioning BH Providers Into the RAE and Provider Network Contracting

As the RAE contractor, **CCHA** was an unknown entity for PCMPs and BH providers in Region 7; and **CCHA** had no pre-existing contracts with any providers in the region. Staff members described an intense process related to contracting and credentialing of providers. Through its relationship with the chief operating officer of the RCCO—ultimately hired by **CCHA**—the RCCO sent messaging in advance of RAE implementation to PCMPs to alert them to the new RAE entity and processes. **CCHA**'s Provider Relations team contacted all RCCO network PCMPs to discuss the terms of the **CCHA** provider contract, which included new payment methodologies. RAE payments for per-member-per-month (PMPM) and performance indicators were perceived as significantly less than similar reimbursements through the RCCO. However, most PCMP practices simultaneously experienced increases in the volume of attributed members due to assignment of previously unattributed members—40 percent of the region—to PCMPs upon RAE implementation. Provider confusion associated with changes in payment methodologies as well as attribution methodologies initially slowed the PCMP contracting process. **CCHA** assessed the impact on each individual practice and ultimately contracted with most of the RCCO PCMP network.

CCHA had no data sources to identify providers currently billing for BH services to enable **CCHA** to contact existing Medicaid BH providers for contracting; however, the CMHC in the region had a previous working relationship with the RCCO and provided services to most BH members in Region 7. Initial contracting with the CMHC was complicated by several issues: the CMHC had been an owner in the BHO and would not be an owner in the RAE; transitioning from the BHO to the RAE contract required changes in reimbursement rates for the CMHC; the Department's initiation of FFS payments for six PCMP BH visits was perceived to be financially disadvantageous for the CMHC's co-located BH providers. **CCHA** worked with the CMHC regarding payment methodologies and successfully executed the CMHC contract.

El Paso DHS identified to **CCHA** its list of numerous core BH providers. Upon contacting these providers for contracting, **CCHA** discovered that contracting with the RAE represented significant change for these providers and that proposed **CCHA** reimbursement rates were considered unacceptable to these providers. In addition, DHS Child Welfare Services highly utilized family preservation program providers, who use unconventional terminology for the specialized services provided to members. UM staff worked with these providers to translate these services into coding for billing Medicaid. **CCHA** began meeting with core providers one-on-one to determine individual provider issues and to clarify funding streams.

To expand the BH independent provider network (IPN), Anthem—**CCHA**'s partner organization—contacted all contracted independent providers prior to RAE implementation to inform them of the opportunity to participate in the Region 7 provider network and provided a contact list to **CCHA** provider contracting staff for follow-up. **CCHA** held a provider town hall meeting at which HFC representatives announced that the RAEs were opening the network to BH independent providers, resulting in a round of applause from providers and an outpouring of interest from independent BH providers. BH providers previously precluded from participating in a BHO began calling **CCHA**'s call center in large numbers and were triaged to the appropriate staff department for assistance. IPN providers had been totally isolated from Medicaid processes including billing, credentialing, and member eligibility processes; many were not previously certified Medicaid providers with the State. Provider relations staff conducted extensive one-on-one, telephonic, and email communications to educate and assist providers through the contracting process. **CCHA** has contracted with 2,000 IPN providers in Region 6 and Region 7 combined.

Staff members stated that **CCHA** has no concerns about the overall adequacy of the expanded provider network in Region 7 and has identified no difficulties with member access to services; however, **CCHA** is still working on filling gaps in services in rural regions. **CCHA** will continue to assess network adequacy ongoing.

Following the initial contracting process for RAE implementation, **CCHA** identified that BH providers were commonly neglecting to bill modifier codes and were not checking member eligibility, resulting in denials of claims. **CCHA** continued payments to providers while resolving these issues, then retroactively adjusted payments as needed. **CCHA** staff considered how to most effectively and proactively communicate each new change to BH providers ongoing. **CCHA**'s provider newsletter dedicates more than 50 percent of content to BH provider topics. Staff stated that BH resources on the provider website are the most frequently accessed component of the website. **CCHA** meets on-site with large BH providers every two weeks, holds regular provider town hall meetings (which are reportedly well-attended), continues open-mic sessions with providers, and maintains one-on-one provider relations staff communications with providers. Practice transformation coaches are working with 45 PCMP practice sites that collectively account for 98 percent of attributed members, and **CCHA** is exploring expanding practice transformation coaching services to support larger BH practices.

CCHA staff reported that 53 PCMP locations are currently billing the six primary care BH visit codes; all such sites have co-located BH providers. Staff members stated that providers remain confused about how to blend billing for the FFS BH visits and the capitated BH visits.

The CMHC has historically offered members the option to visit a CMHC office near their home to access therapists through telehealth services. **CCHA** is exploring the potential for expansion of behavioral telehealth services in the region through resources provided by **CCHA**'s Anthem partner. Ieso Digital Health is an online phone texting behavioral health therapy application. Using a typed, written exchange between the member and a licensed BH clinician, Ieso replaces the need for face-to-face therapy with a BH provider, thereby eliminating travel concerns or restricted hours for appointments. It also provides the member an opportunity to seek therapy with clinicians located out of the area, and eliminates inhibitions associated with personal visits to BH provider offices in small towns.

Opportunities/Challenges

Processes for transitioning members and providers into the RAE were complicated by lack of a working relationship between the regional BHO and **CCHA**, requiring **CCHA** to employ alternative workaround mechanisms to identify BH providers and members receiving BH services. In addition, previous BHO contracts and payment mechanisms with BHO providers varied from **CCHA** reimbursement terms and delayed contracting with some BH providers. All of these transition issues required **CCHA** to commit extensive and nimble resources to successfully transition BH into the RAE.

As previously stated, the Department's enrollment and attribution systems failed to initially incorporate PCMP-specified limits on the size of Medicaid member panels, creating significant stress related to appropriate member attribution to PCMPs. The Department's attribution methodology also impacted specialized member populations.

CCHA staff indicated that the bifurcated FFS and capitated payment system for the RAEs is challenging for providers, especially integrated practice providers. The payment system also creates data source challenges for some RAE processes, including those related to performance measures dependent on access to both FFS and capitated data. Staff also cited that the RAE continues to sort through laws regarding access to SUD data.

CCHA highlighted several perceived successes of implementing the integrated RAE model as follows:

- Member choice issues have been exceedingly satisfied by expansion of the BH IPN. Member and provider negative perspectives regarding barriers to care in the BHO have been alleviated. Overall utilization of BH services and the BH penetration rate will most likely increase.
- ACN providers have developed information exchange workflows with the CMHC.
- Integrated practice locations of primary care and behavioral health co-located providers will likely continue to increase because co-located BH providers are not required to be placed through the BHO.
- Region 7 providers and community organizations have a long history of working together on local healthcare initiatives and concerns. **CCHA** has been able to transition many of those relationships and can build on them. The expanded availability of BH providers has and will most likely continue to offer opportunities for closer working relationships among physical health and behavioral health providers and community partners.
- **CCHA** staff members believe that the new RAE model has had a positive effect on members. BH integration is much better for whole-person care. The development of integrated care teams, systems, and care plans for members represents best practice and better healthcare.
- Whereas the RCCO was the facilitator of collaborative activities in the community related to physical health services, implementation of the RAE has positioned the RAE to facilitate community relationships for both physical and behavioral health services—i.e., "Medicaid program" facilitators.