CHP+

Child Health Plan *Plus*

Fiscal Year 2024–2025 Compliance Review Report

for

Colorado Access

February 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (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.

Colorado Access (COA) showed a strong understanding of the federal regulations reviewed, with all three standards scored *Met*. COA maintained an overall 100 percent for all of the standards with *Met* findings compared with the standard scores from the prior review.

Table 1-1 presents the scores for COA for each of the standards. Findings for all requirements are summarized in Section 2—Assessment and Findings. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* are included in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the 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, Protections, and Confidentiality	5	5	5	0	0	0	100%~
VIII. Credentialing and Recredentialing	32	31	31	0	0	1	100%~
Totals	**48**	**47**	**47**	**0**	**0**	**1**	**100%**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

Table 1-2 presents the scores for COA for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are included in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	79	79	79	0	0	100%~
Recredentialing	60	60	60	0	0	100%~
Totals	**139**	**139**	**139**	**0**	**0**	**100%~**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

COA provided evidence of policies and procedures and a thorough description during the interview of its care coordination program structure. The care coordination program included a multi-disciplinary team of experienced staff members. The care coordination program included several teams that had an array of responsibilities for each special case. Members in need of care coordination could be identified by methods such as utilization management, population health tools, admission or discharge data, health risk assessments, outreach and screening, and referrals from family members or self-referrals. Once a member identified with a need and was enrolled into the care coordination program, COA reported the member received ongoing support, resources, and communications from their assigned care coordinator and care manager.

Although staff members could not report on specific numbers for how many members receive care coordination services for Child Health Plan *Plus* (CHP+), staff members reported it serviced an estimate of 3,000 members across all lines of business. Member outreach is attempted multiple times through phone calls and mail. Care coordinator contact information can be found within the letter the member receives. As for pregnant members, once identified, COA staff members outreach the member and ask a variety of questions from an evidence-based assessment. All contacts with members are documented and tracked in the HealthEdge GuidingCare workflow management system.

The policy, Transitions of Care, described how members were transitioned between different healthcare settings. Staff reported that members are supported by a team of care coordinators and care managers to ensure a smooth transition from a multitude of different types of healthcare settings. COA reported that this process ensures continuity of care through transitions such as inpatient care settings, emergency department (ED) visits, between managed care plans, and child to adult transitions. As for ensuring services are not duplicated, COA shares information between providers, care coordinators, and other care team members. Within the Care Coordination policy COA described how sharing assessment and evaluation results assist with care plan design, goal setting, both short- and long-term interventions, and actively preventing duplication of services.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

COA staff members reported that it provided members with information pertaining to their rights and responsibilities through the CHP+ member handbook and through the website at any time and members could receive a copy upon request, at no charge. The CHP+ member handbook listed the rights and responsibilities that are required in accordance with the federal regulations at 42 CFR 438.100. In addition, during the interview, COA noted that staff members and providers were trained on member rights to ensure that staff members and providers could assist CHP+ members with their rights and responsibilities. COA provided a member rights policy to which COA staff members and providers regularly have access.

The Non-Discrimination policy described how COA does not discriminate against individuals—including those with disabilities—in all areas of public life, and provides equal access to its services, benefits, and programs. The policy also noted a member can submit a complaint if they felt discriminated against, and how to do so. COA staff members confirmed during the review that any reported member rights issue would be investigated and sufficiently resolved.

COA submitted multiple documents that described how COA ensured the confidentiality of protected health information (PHI) when creating, maintaining, and sharing information. COA outlined measures to ensure the necessary safeguards were in place regarding sharing member PHI, including secure information exchange (i.e., encrypted emails), and use of authorizations to disclose PHI.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

COA demonstrated comprehensive compliance with National Committee for Quality Assurance (NCQA) standards through robust credentialing and recredentialing policies and procedures for both practitioners and organizations. COA provided detailed descriptions of its credentialing department, associated software systems, credentialing committee composition, and the thorough application review process. Throughout the interview, COA demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures.

COA's credentialing process included a thorough file verification, with varying levels of review based on file complexity. After receiving an application, credentialing staff members verified information within the files. COA described the evaluation process for files, depending on the level of review required. Clean files were approved by the medical director on a daily basis, while more complex files required in-depth review and discussion by the credentialing committee.

COA's credentialing committee is comprised of diverse member qualifications and specialties, including physicians, counselors, and a nurse midwife. COA's credentialing policies extensively detailed the process for conducting credentialing and recredentialing in a nondiscriminatory manner. Further, all credentialing committee members complete nondiscrimination attestations on an annual basis. COA also described a process to conduct audits of files that may suggest potential discriminatory practice or if a practitioner complains about alleged discrimination.

COA reported that it averaged a 21-day turnaround time for review and decision-making of initial credentialing files in calendar year (CY) 2024. HSAG reviewed a sample of initial credentialing files and found that COA processed all records in a timely manner. Each initial credentialing file included Council for Affordable Quality Healthcare (CAQH) applications, evidence of license and education verification through the Colorado Department of Regulatory Agencies (DORA), verification of work history in the most recent five years, professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner in the most recent five years, and the Drug Enforcement Administration (DEA) verification and board certification verification, if applicable. HSAG also reviewed a sample of recredentialing files and found that COA appropriately recredentialed providers and organizations within the 36-month time frame. Further, COA provided evidence that it conducted ongoing monitoring of practitioners and organizations through National Practitioner Data Bank (NPDB) continuous query monitoring and DORA.

During the interview, COA described additional monitoring of practitioners and organizations that occurred between credentialing cycles, which included reviews of provider-specific member grievances and occurrences of adverse events, such as quality of care concerns. COA described a process that included direct lines of communication between COA's credentialing and quality management

departments, wherein any quality of care concerns were forwarded to the Credentialing Committee for further investigation and corrective action.

COA delegated credentialing and recredentialing activities to numerous contracted organizations. Annual monitoring of delegates was conducted by COA through a delegation audit, ensuring compliance with activities, responsibilities, and reporting. Per COA, delegates in recent years have been successful during the annual audit and met the 95 percent benchmark.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

3. Background and Overview

Background

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) to comply with provisions of Title 42 of the Code of Federal Regulations (42 CFR) Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in December 2020, February 2023, and May 2024. The Department of Health Care Policy & Financing (the Department) administers and oversees the CHP+ program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), HSAG.

To evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2024–2025 was CY 2024. This report documents results of the FY 2024–2025 compliance review activities for COA. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, CHP+ MCO, and Department personnel who participated in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[1] Appendix F contains details of care coordination special focus topic discussions that took place during the virtual compliance review.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 20, 2024.

Overview of FY 2024–2025 Compliance Monitoring Activities

For the FY 2024–2025 compliance review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools for the three chosen standards:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the three standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the CHP+ MCOs' contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The three standards chosen for the FY 2024–2025 compliance 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—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the CHP+ MCO regarding:

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

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each CHP+ MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the CHP+ MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the CHP+ MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with the CHP+ MCO until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

For FY 2023–2024, HSAG reviewed Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems.

Related to Standard V—Member Information Requirements, COA was required to complete one required action:

- Revise its provider directory to include the provider URLs.

Related to Standard VII—Provider Selection and Program Integrity, COA was required to complete one required action:

- Update its sanctions and exclusions policies and procedures to align in full detail with the federal and State requirements that COA would not knowingly employ any staff members who are debarred or suspended.

Related to Standard IX—Subcontractual Relationships and Delegation, COA was required to complete three required actions:

- Maintain ultimate responsibility for subcontractor agreements by ensuring centralized oversight (i.e., by the legal department) of all agreements and ensure that a process is outlined (e.g., a desktop procedure or policy) that addresses CAPs in relation to subcontractor performance.
- Ensure that all contracts, including the contract with OneTouchPoint Mountain States, LLC, specify the delegated activities or obligations and related reporting responsibilities.

- Guarantee, via revisions or amendments, that subcontractor agreements include:
  - The State, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the contractor's contract with the State.
    - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
    - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    - If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Related to Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, HSAG found no required actions for this standard.

Summary of Corrective Action/Document Review

COA submitted a proposed CAP in April 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to COA. COA submitted final documentation and completed the CAP in July 2024.

Summary of Continued Required Actions

COA successfully completed the FY 2023–2024 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3	• CM100 Colorado Access Care Coordination ○ Purpose page 2-describes at a high level how we deliver care to meet the standards to support care coordination for our members ○ Statement of policy page 2-3 ▪ B,C,D,F,G-these discuss timely access, making sure members/caregivers are involved in care planning and discusses gap closure and support in connecting to resources and providers to meet members needs ○ 2A Facilitation of Care Coordination numbers 1-3 page 5-discusses how we involve the member and their caregiver, how care planning and care coordination may take place with providers and others ○ 2B Facilitation of Care Coordination numbers 1-3 page 5, this discusses how we assess and identify needs of the member ○ 2C Facilitation of Care Coordination numbers 1-10 pages	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	5-7, this section discusses interventions we provide once we have identified members needs and how we may work with several entities to coordinate • CM101 Delivering Continuity and Transitions of Care ○ Statement of policy page 2-describes continuity of care ○ Procedures number 2D page 4 discusses a 60-day transition period for ongoing course of treatment Procedures number 2E and the 3 bullets listed page 4 with it-discusses single case agreements and how to support members if a provider won't contract and criteria around how long they can have a service from previous provider	
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's 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 the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—10.5.3.1	• CHP Member Handbook ○ Getting Involved in Care Management Page 92- this talks about care management and how to reach out if a member has a need • CM100 Colorado Access Care Coordination • 2A number 3, page 5- this discusses that the member will be provided with their	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care coordinators name as well as info about other members of their care team	
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B—10.5.3.2.1, 10.5.3.2.1.1–2, 10.5.3.2.1.4	• CM100 Colorado Access Care Coordination ○ Definitions- Care Coordination page 1-the definition includes pieces on coordinating with others ○ Purpose page 2-discusses coordinating across healthcare settings, community agencies and with others ○ Statement of policy pages 2-4 ○ Entire Facilitation of Care-discusses all the ways we may help coordinate care for members Coordination pages 5-7 CM101Delivering Continuity and Transitions of Care to Members ○ Statement of Policy page 2-discusses we may coordinate with the other plan and others and share health information about member COA DLP Transitions of Care (Admissions and Discharge)-page 2 section 3. High level	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	description numbers 3-8 discuss assisting with discharge COA DLP QRTP/PRTF- page 3 number 3, number 12 and 13 describe coordinating with facility IDT meeting and assisting with discharge	
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4	• CM DP10 CHP+ HRA_10.2024 – this clearly documents the health risk assessment screening process including attempts, screening questions and care coordination activity with member. ○ Background ○ Procedure 2, A ○ Procedure 2, D ○ Procedure 3, B ○ Procedure 3, C, 1-4 ○ Appendix A: HRA Survey ○ COA_DLP_Member Onboarding – Workflow guides care staff through a visual process map and details how to accurately document in GuidingCare.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor shall complete an evidence-based risk assessment for all pregnant members (unless member declines or is unable to be reached) within seven business days of identifying a pregnant member. • Contractor must conduct outreach to initiate service coordination activities within seven business days of designating a high-risk pregnancy. Contract: Exhibit B— 10.1.6.1, 10.1.6.2	• CHP_Prenatal_HRA_GCScript_11.2024 – lists all the prenatal health risk assessment questions. • COA_DLP_Pregnancy – ○ Care Coordinator/Care Manager swim lane in Workflow Pg 3 ○ Section 5 ○ CHP Prenatal SSRS Report Screenshot- weekly report sent to Care Management identifying members for outreach within 7 days.	*Information Only*
6. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.4.1.3	○ CM100 Colorado Access Care Coordination ○ Facilitation of Care Coordination 2B number 3 page 5 this discusses sharing care plans and info with care team to mitigate duplicative efforts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—10.5.6	• PRI100 Protecting Member PHI • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI • PRI104 Member Rights and Requests Regarding PHI	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• PRI105 Personal Representatives and Member PHI • PRI200 Sanctions Policy • PRI204 Security of EPHI	
8. The Contractor 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 applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.5.9, 13.1.2	• CM100 Colorado Access Care Coordination ○ Statement of policy page 3 discusses protecting confidentiality • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)*	• CM100 Colorado Access Care Coordination ○ Definition ▪ Special Health Care Needs ▪ Facilitation of Care Coordination number 2B number 2 page 5, discusses members being referred to care management for care coordination to assess ,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—10.5.9.1.1	create care plans and follow up • CM DP10 CHP+ HRA_10.2024- this clearly documents the health risk assessment screening process including attempts, all screening questions, special health care needs screen question, and care coordination requirements with member. ○ Background ○ Procedure 2, A ○ Procedure 2, D ○ Procedure 3, B ○ Procedure 3, C, 1-4 ○ Appendix A: HRA Survey COA_DLP_Member Onboarding – Workflow guides care staff through a visual process map and details how to accurately document in GuidingCare. COA_DLP_Chronic_Conditions – Workflow details outreach and required activities for members with chronic conditions.	
10. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor).	• CM DP10 CHP+ HRA_10.2024 ○ Background, 3rd paragraph, details the annual call back if identified with special health care needs. ○ Procedure 3, C, 1-4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to prior-authorization requests). • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.9.1.2-3	○ Procedure 3, D and E 1-4, and F ○ Appendix B: Annual HRA Call back question	
11. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.9.1.4	CM101 Delivering Continuity and Transition of Care for Members ○ Procedures number 2D-G discusses if member is in ongoing course of treatment and ensuring they can maintain for 60 days and how we will support members to identify new provider if provider is not willing to contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—7.3.6.1	CS212 Member Rights and Responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., nondiscrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B—15.10.9.2	• ADM205 Nondiscrimination ○ Policy Statement • ADM230 Member Disability Rights Request and Complaint Resolution ○ Policy Statement • CS212 Member Rights and Responsibilities ○ Policy Statement second paragraph • Provider Manual Section 2 ○ Page 8 Nondiscrimination ○ Page 12 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/ https://www.coaccess.com/nondiscrimination/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor'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 the member's 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 their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—7.3.6.2-6	• CS212 Member Rights and Responsibilities ○ Policy Statement bulleted list • ADM208 Member Materials • Provider Manual Section 2 ○ Page 12 Member Rights and Responsibilities • Colorado Access Website: ○ https://www.coaccess.com/members/services/rights/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—7.3.6.3.7	• ADM203 Member Grievances ○ Grievance Definition ○ Procedures Section 1 • Provider Manual Section 2 ○ Page 12 Member Rights and Responsibilities • COA Website ○ https://www.coaccess.com/members/services/rights/ • CHP Handbook • Pages 17-19	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor 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: Exhibit B—10.5.5.9, 13.1.2	• PRI100 Protecting Member PHI • PRI101 Clinical Staff Use and Disclosure of Member PHI • PRI103 Authorizations to Disclose Member PHI • PRI104 Member Rights and Requests Regarding PHI • PRI105 Personal Representatives and Member PHI • PRI200 Sanctions Policy • PRI204 Security of EPHI • See COA Website ○ http://www.coaccess.com/documents/Notice-of-Privacy-Practices.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B—9.2.3, 9.2.3.1	• CR301 Provider Credentialing and Recredentialing • CR305 Assessment of Organizational Providers • CR DP18 Credentialing Initial Providers • CR DP21 Recredentialing Practitioners • CR DP24 Organizational Credentialing Assessments The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *42 CFR 438.214(a–b1)* NCQA CR1—Element A1	• CR301 Provider Credentialing and Recredentialing (pages 2-3) • CR305 Assessment of Organizational Providers (page 1) • PNS202 Selection and Retention of Providers The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.B. The verification sources it uses. NCQA CR1—Element A2	• CR301 Provider Credentialing and Recredentialing (pages 8-11) • CR305 Assessment of Organizational Providers (pages 5-7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	• CR301 Provider Credentialing and Recredentialing (pages 11-13) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	• CR301 Provider Credentialing and Recredentialing (pages 11-13) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	• CR301 Provider Credentialing and Recredentialing (pages 11-15) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	• CR301 Provider Credentialing and Recredentialing (pages 3-4) • Signed Committee Confidentiality Non-discrimination Statements The policies follow NCQA credentialing standards, and the Committee members sign statements every year.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights The Credentialing Coordinators reach out to the provider to allow them to make updates to their documentation as needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	• CR301 Provider Credentialing and Recredentialing (page 13) • CR305 Assessment of Organizational Providers (page 7) Approval letters are mailed every Monday for the previous week's approvals	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	• CR301 - Provider Credentialing and Recredentialing (pages 3, 13) • CR305 Assessment of Organizational Providers (page 7) • CR DP04 Ongoing Monitoring of Providers • CR DP23 Monthly Ongoing Monitoring of Sanctions The policies follow NCQA credentialing standards. The Senior Medical Director signs off on clean files daily and we have co-chairs to run the monthly Credentialing Committee meetings.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	• CR301 Provider Credentialing and Recredentialing (pages 4-5) • Signed Confidentiality and Non-discrimination Statements The policies follow NCQA credentialing standards. Files are maintained on a secured drive, and only certain staff have access to this drive.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	• CR301 Provider Credentialing and Recredentialing (page 13) • CR305 Assessment of Organizational Providers (pages 7-8) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights • Provider Manual (revised) Credentialing policies are posted on our website and in the provider manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights • Provider Manual (revised) The Credentialing Coordinators reach out to the provider to allow them to make updates to their documentation as needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	• CR301 Provider Credentialing and Recredentialing (page 4) • CR DP01 Provider Rights • Provider Manual (revised) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	• CR301 Provider Credentialing and Recredentialing (pages 1, 4-7, 11-13 • CR305 Assessment of Organizational Providers (page 7) • CR DP04 On-going Monitoring of Providers (pages 3-4) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	• Credentialing Committee Members 10-18-24 • CR301 Provider Credentialing and Recredentialing (pages 4, 6-7, 11-13) • CR305 Assessment of Organizational Providers (page 7) The policies follow NCQA credentialing standards. The Senior Medical Director signs off on clean files daily and the Credentialing Committee meets once a month.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days).	• CR301 Provider Credentialing and Recredentialing (pages 5, 8-11) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	• CMP206 Sanctions Screening • CR301 Provider Credentialing and Recredentialing (pages 10-11) • CR305 Assessment of Organizational Providers (pages 5-6) • CR DP04 On-going Monitoring of Providers The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions.	• CR301 Provider Credentialing and Recredentialing (pages 5, 7, 10) • CR305 Assessment of Organizational Providers (pages 2, 6) The policies follow NCQA credentialing standards. The Colorado CAQH application meets this standard.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	• CR301 Provider Credentialing and Recredentialing (page 2) • CR305 Assessment of Organizational Providers (page 1) The policies follow NCQA credentialing standards. Colorado Access has not had a late file in 2024.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events.	• CR301 Provider Credentialing and Recredentialing (pages 7-8) • QM201 Quality of Care Concern Investigations • CMP206 Sanction and Exclusion Screening • CR DP04 Ongoing Monitoring of Providers The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A		
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	• CR301 Provider Credentialing and Recredentialing (pages 7-8) • CR305 Assessment of Organizational Providers (page 7) • QM201 Quality of Care Concern Investigations • CR DP04 Ongoing Monitoring of Providers The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter:	• CR305 Assessment of Organizational Providers • CR DP04 Ongoing Monitoring of Providers The policies follow NCQA credentialing standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)* NCQA CR7—Element A1		
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	• CR305 Assessment of Organizational Providers (pages 2-4, 6-7) The policies follow NCQA credentialing standards	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.*	• CR305 Assessment of Organizational Providers (pages6-7) • Office Site Visit Form The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.) NCQA CR7—Element A3		
13. The Contractor's organizational provider assessment policies and processes include: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7—Elements B and C	• CR305 Assessment of Organizational Providers (page 1) The policies follow NCQA credentialing standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has documentation that it assesses providers every 36 months. NCQA HP CR7—Elements D and E	• CR305 Assessment of Organizational Providers (page 1) • CR DP02 Organizational Assessment and File Audit The policies follow NCQA credentialing standards. Colorado Access has not had a late file in 2024.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	• ADM223 Delegation • CR301 Provider Credentialing and Recredentialing (page 4) The policies follow NCQA credentialing standards. Credentialing Delegation Agreement June 2024	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	NA	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates	• ADM223 Delegation • CR301 Provider Credentialing and Recredentialing (page 4) • Delegation Audit Notification Letter • Delegation Audit Results Letter • Credentialing Delegation Tool Results • 2024 Delegation Audit Task Checklist The policies follow NCQA credentialing standards. The Delegation Audit Task Checklist, along with reminder tasks ensures the annual audits are completed timely.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
improvement for one finding over three consecutive quarters. NCQA CR8—Element C		
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	CR DP15 Delegation Audit Process There have not been any corrective action plans for our list of delegates in the past year.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Colorado Access CHP+

Review Period:	1/1/2024–12/31/2024
Completed By:	Travis Roth
Date of Review:	12/10/2024
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Travis Roth

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	PA	PhD	OT	OD	MD	MD	LPC	NP	LCSW	DO
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Physician Assistant	Psychology	Occupational Therapy	Optometry	Family Medicine	Ophthalmology	Licensed Professional Counselor	Nurse Practitioner	Licensed Clinical Social Worker	General Medicine
Date of Completed Application [MM/DD/YYYY]	10/12/2023	1/26/2024	1/26/2024	11/13/2023	1/31/2024	4/15/2024	6/10/2024	6/6/2024	7/11/2024	8/27/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/19/2024	1/30/2024	2/9/2024	2/23/2024	3/4/2024	5/20/2024	6/12/2024	7/18/2024	8/30/2024	9/9/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	Yes	NA	Yes	NA	Yes	Yes	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	Met	NA	Met	NA	Met	Met	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	Yes	NA	NA	NA	Yes	Yes	NA	Yes	NA	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	Met	NA	NA	NA	Met	Met	NA	Met	NA	Met
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Colorado Access CHP+

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	9	7	8	7	9	9	7	8	7	8
Compliant (Met) Elements	9	7	8	7	9	9	7	8	7	8
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	79									
Total Compliant Elements	79									
Total Percent Compliant	100%									

Notes:

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

Prior to Credentialing Decision
- DEA or CDS certificate
- Education and training

180 Calendar Days
- Current, valid license
- Board certification status
- Malpractice history
- Exclusion from federal programs

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Colorado Access CHP+

Review Period:	1/1/2024–12/31/2024
Completed By:	Travis Roth
Date of Review:	12/10/2024
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Travis Roth

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	DO	MD	MD	OD	LPC	LCSW	MD	LCSW	MD	LPC
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Obstetrics and Gynecology	Family Medicine	Orthopaedic Surgery	Optometry	Licensed Professional Counselor	Licensed Clinical Social Worker	Pulmonary Disease	Licensed Clinical Social Worker	Family Medicine	Licensed Professional Counselor
Date of Last Credentialing [MM/DD/YYYY]	2/24/2021	2/25/2021	4/29/2021	5/20/2021	7/26/2021	4/14/2021	9/24/2021	9/10/2021	10/6/2021	11/16/2021
Date of Recredentialing [MM/DD/YYYY]	1/26/2024	1/15/2024	3/27/2024	4/11/2024	6/18/2024	3/15/2024	8/23/2024	8/12/2024	9/13/2024	10/2/2024
Months From Initial Credentialing to Recredentialing	35	34	34	34	34	35	34	35	35	34
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	Yes	Yes	Yes	NA	NA	NA	Yes	NA	Yes	NA
Evidence of Board Certification Met? [VIII.6]	Met	Met	Met	NA	NA	NA	Met	NA	Met	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	Yes	Yes	Yes	NA	NA	NA	Yes	NA	Yes	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	Met	Met	Met	NA	NA	NA	Met	NA	Met	NA
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Colorado Access CHP+

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	7	7	7	5	5	5	7	5	7	5
Total Compliant (Met) Elements	7	7	7	5	5	5	7	5	7	5
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**60**									
Total Compliant Elements	**60**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

   180 Calendar Days
   - Current, valid license
   - Board certification status
   - Malpractice history
   - Exclusion from federal programs

   365 Calendar Days
   - Signed application/attestation
9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2024–2025 compliance review of COA.

Table C-1—HSAG Reviewers, COA Participants, and Department Observers

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
COA Participants	**Title**
Rachel Williamson	Manager of Compliance and Privacy
Marcy Mullan	Director of Compliance Programs
Lisa Hug	Director of Program Deliverables
Ward Peterson	Director of Enrollment and Child Health Plan Plus
John Priddy	Vice President of Health Plan Operations
Taylor Mitchell	Child Health Plan Plus Program Manager
Jamie Zajac	Director of Care Management
Marsha Aliaga-Dickens	Manager of Care Management
Thomas Mayo	Director of Utilization Management
Josette Hizon	Supervisor of Behavioral Health Utilization Management
Travis Roth	Manager of Credentialing and Provider Data
Kathy Nyberg	Legal Services Manager
Reyna Garcia	Senior Director of Customer Service
Kate Myers	Health Programs Specialist
Claire Peters	Director of Populations Health
Kris Cooper	Supervisor of Behavioral Health Utilization Management
Sheryl McCully	Manager of Utilization Management
Natasha Wade	Care Manager II
Ann Edelman	Chief Legal Officer and Vice President of Compliance
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2024–2025

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE must submit documents based on the approved timeline.

Table D-1—CAP Process

Step	Action
Step 1	**CAPs are submitted**
If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE 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, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE 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 MCE 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 resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

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

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.

Table E-1—Compliance Monitoring Review Activities Performed

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

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved FY 2024–2025 Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.

Care Coordination

The purpose of the CHP+ Special Focus Topic: Care Coordination interview was to explore the trends, strengths, and challenges that each Colorado CHP+ plan has experienced with the evolution of its care coordination program. A sample of topics covered in each CHP+ discussion included the rate of completion for initial screenings, specifically among members with high-risk pregnancies; addressing health-related social needs (HRSN) and equity; describing successful partnerships and barriers; coordinating chronic disease management; and handoff processes for transitions of care. The discussion with COA centered on various aspects of the program, including screenings, care coordination, transitions of care, and addressing health disparities.

Screenings and Assessments

HSAG inquired about general screenings and the 90-day completion requirement. While COA lacked specific data on initial health risk assessments, it reported an average of 460 screenings completed monthly, a significant increase from previous years. COA highlighted the 2024 revision of their health risk assessment, which improved the structure, flow, and inclusion of HRSN questions, leading to higher completion rates. COA contracted with an automated survey administration vendor, which can lead to potential challenges in obtaining accurate information. However, COA mitigated this risk through careful questioning and follow-up.

Regarding high-risk pregnancies, COA's care coordination team receives weekly files and contacts members to complete assessments. Challenges in obtaining timely responses were acknowledged, and COA committed to further investigate completion rates. The pregnancy assessment revisions focused on identifying high-risk factors through targeted questions.

Care Coordination and Transitions of Care

HSAG explored COA's care coordination toolkit and its evolution. COA emphasized a workflow-based approach, with specific tasks and prompts to guide staff through key activities, such as scheduling appointments, setting reminders, and conducting assessments. The toolkit also included documents for capturing members' communication preferences. COA shared strategies for providing support to families, such as sharing resources, connecting with home health agencies, and navigating non-covered benefits like Applied Behavioral Analysis.

Addressing Health Disparities

COA has implemented various strategies to address health disparities, including language support, accessible website design, and partnerships with advocacy groups. COA has partnered with organizations like Project Angel Heart to provide additional support to members with specific health conditions. COA has identified non-emergent transport as a significant barrier for members and is exploring potential solutions. COA has implemented strategies to address food insecurity, such as referring members to the Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC) program, and local food pantries.

Chronic Disease Management

COA utilizes dashboards and work queues to identify members with chronic conditions and coordinate appropriate care. COA noted that it had a direct contact at DentaQuest it could outreach to assist members with getting specialized dental care. COA collaborates with providers to address the complex needs of members with both mental health and chronic conditions. Challenges related to transportation were discussed, along with strategies to improve access.

Finally, COA shared examples of partnerships with organizations like Mama Bird Doula Services to provide valuable birthing and mental health resources and support to members of color. COA also shared how it navigated complex cases, including a member with DiGeorge syndrome, by coordinating care between multiple providers and addressing enrollment challenges.

HSAG identified the following strengths related to care coordination:

- A robust care coordination toolkit and workflow that guides staff through key activities, ensuring comprehensive support for members.
- The identification and partnership with varied community organizations to meet HRSNs and support equity within its member population.
- The commitment to continuous learning and improvement in acquiring and maintain engagement once a member is accepted into coordinated care.

HSAG identified the following opportunities related to care coordination:

- Continue to identify and implement strategies to improve the rate of administering health assessments to new members and members who have not been assessed recently or ever.
- Conduct regular evaluations to assess the effectiveness of the program, particularly in the areas emphasized during the review, and identify areas for improvement.
- Continue establishing and enhancing feedback mechanisms to gather input from a diverse group of members, staff, and stakeholders.