COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2023–2024 Compliance Review Report

for

Colorado Community Health Alliance

Region 6

May 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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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 Community Health Alliance (CCHA) demonstrated a strong understanding of member information, provider selection and program integrity, and quality assessment and performance improvement requirements and a moderate understanding of federal regulations for subcontracts and delegations.

Table 1-1 presents the scores for CCHA RAE 6 for each of the standards. Findings for all requirements are summarized in the Assessment and Findings 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)
V. Member Information Requirements	18	18	18	0	0	0	100% ^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100%~
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75% v
X. Quality Assessment and Performance Improvement (QAPI)**	16	16	16	0	0	0	100%~
Totals	**54**	**54**	**53**	**1**	**0**	**0**	**98%**

*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.

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

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

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

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

CCHA used a process to provide member information to members during their initial enrollment, when requested, at no cost, in English and prevalent non-English languages and in alternative formats. CCHA staff members reported that customer service representatives assisted members by providing guidance during calls when members had questions or concerns. Customer services representatives were trained on member benefits via onboarding, periodic training, and one-on-one communications. CCHA staff members directed members to the current member handbook and additional critical information hosted on CCHA's website.

CCHA described in detail how member materials were reviewed and tested for reading level and compliance with Section 508 of the Rehabilitation Act (Section 508). Member materials were tested for grade level accuracy through member and staff collaborations. Staff members reported receiving feedback that allowed for corrections to ensure that members had a better understanding of the materials. CCHA staff members reported using UserWay to ensure compliance with Section 508. When asked how errors were found and addressed, CCHA staff members described the process to identify errors, monitor risk levels, and quickly resolve errors. HSAG reviewed and tested the PDF materials and the websites and found a low number of errors.

Interpretation services were made available free of charge to members upon request. CCHA staff members described a process for members to receive language assistance by being connected with bilingual staff members who are employed with CCHA or with a third-party vendor, CyraCom International, Inc.

The provider directory was updated daily. Validations were conducted through different approaches, such as a banner located on the provider directory webpage requesting updates from providers and members. Validation was conducted on all input from the digital forms before being entered into the system.

Opportunities for Improvement and Recommendations

HSAG reviewed multiple member letters and member notices that could be mailed to the member upon request. Tag lines in some member letters and member notices were not internally consistent or they did not include the same components in Spanish as in English. HSAG recommends that CCHA conducts a review of its member written material to ensure that all tag lines are consistent in both English and Spanish.

Required Actions

HSAG identified no required actions for this standard.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

CCHA's policies and procedures pertaining to the selection and retention of providers noted that CCHA was willing to recruit and contract with a provider in good standing with CMS who was enrolled in the Colorado Medicaid Program. In addition to meeting qualification criteria, CCHA encouraged providers to offer appointments outside of typical workday hours and to provide phone coverage with a clinician who could triage a member's health needs 24 hours a day, seven days a week.

CCHA did not identify any challenges specific to provider recruitment. Per staff member interview, CCHA utilized tools to identify and fill gaps within the provider network to meet member needs. The CCHA Annual BH [Behavioral Health] Recruitment Strategy-CO [Colorado] policy identified these tools as processed claims, member requests, care coordination, and utilization management.

CCHA policy referenced the following as activities that support provider retention: initial orientation, bi-annual town hall meetings, monthly provider newsletters, a provider portal, an online provider manual, open mic sessions, and targeted educational offerings. In addition to these retention activities, the CCHA community incentive program funded individual providers and practices for non-billable services.

HSAG reviewed the CCHA RAE 6-specific compliance plan and compliance policies, which addressed staff member and provider education as well as compliance activities that included claims reviews, data mining, auditing, and risk assessments. As described in the policy, CCHA sent monthly letters to a sampling of CCHA members to verify that services billed had been received by the members.

CCHA's compliance committee managed compliance activities for the region and the compliance officer reported quarterly to the CCHA board. Compliance policies included procedures for monitoring, auditing, and investigating potential compliance issues. CCHA trained its employees to recognize and submit concerns about fraud, waste, or abuse to the Special Investigations Unit (SIU). CCHA tracked claims overpayments and conducted follow-up and data mining to monitor trends as needed.

CCHA provided its Excluded Individuals and Entities policy and Credentialing policy, which described procedures for verification and notification regarding excluded individuals. CCHA submitted evidence of a monthly review process for the United States Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) for current providers, board members, employees, and contractors.

Employees were trained on compliance at the time of hire and annually. Employee training and contracted vendor training included standardized compliance education and a review of the organization's Code of Conduct, which required a signature acknowledgment from each staff member.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

CCHA has written delegation agreements for the following services: credentialing, language and translation services, care coordination, the community resource directory, and record retrieval. HSAG reviewed a sample of the delegation agreements to determine compliance with federal requirements. According to the staff member interview, CCHA's contract management system links with CCHA's core values of governance, risk, and compliance, beginning with the request to outsource and ending with the development of contract language. The written agreements included language that required the subcontractor to comply with all applicable laws, regulations, and applicable subregulatory guidance and contract provisions.

During the interview, CCHA staff members discussed utilization of pre-delegation audits and reviews of policies and procedures to evaluate a potential subcontractor's ability to provide the subcontracted services. Following execution of a delegation agreement, subcontractors were monitored via audits and regular meetings with the subcontractor, as applicable, to review outcomes. During the interview, CCHA staff members discussed the monitoring and oversight process as it related to a subcontractor for care coordination services and submitted evidence of a completed audit.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG reviewed a sample of contracts across the delegated activities and found that some of the written agreements did not include the required language. CCHA must ensure, via revisions or amendments, that all subcontractor agreements include the following language:

- The State, CMS, the 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.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

Evidence of Compliance and Strengths

HSAG reviewed the CCHA RAE 6-specific quality improvement plan (QIP), which documented a comprehensive quality assessment and performance improvement (QAPI) program that described the leadership structure, goals and objectives, and program components encompassing both physical and behavioral health (BH). CCHA maintained an active multidisciplinary quality management committee, identified priority populations and programs, and noted processes related to each component of the QAPI program.

CCHA's QIP addressed key performance indicators and performance pool measures and described an improvement initiative for each measure that frequently included provider or practice engagement. Progress toward goals was monitored through performance dashboards. CCHA coordinated multidisciplinary team meetings to address various aspects of its quality program. Mechanisms were in place to detect and address over- and underutilization of services. In collaboration with community providers, CCHA implemented pilot programs targeting specific populations, to decrease hospital readmissions and inappropriate emergency department use.

CCHA established processes to identify, report, and investigate quality of care concerns, including a referral form made available to providers and CCHA staff members. CCHA facilitated meetings with providers to address quality of care trends and opportunities for improvement.

BH clinical practice guidelines provided by Elevance Health were reviewed and discussed through CCHA's advisory committee before they were adopted. CCHA made the approved guidelines available on its website, accessible to both providers and members. In addition, within its provider newsletter, CCHA informed providers of each available guideline and where it was sourced.

CCHA submitted a flowchart that demonstrated their health information system process from inputs to data master file, through data decision support to output. CCHA submitted an Elevance Health information systems management overview that described the process of receiving, processing, and reporting data to and from the State. The Quality Office System Review policy and procedure illustrated how annual collection of the office system review was conducted and how it identified areas for improvement to make updates to the master data. During the interview, CCHA discussed its health information system, from daily member enrollment to encounter data processing to various reporting mechanisms. CCHA staff members described in detail the life cycle of the health information system, which has not had any updates in the last two years.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG identified no required actions for this standard.

3. Background and Overview

Background

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Health Care Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers (PCPs) and capitated BH providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PIHPs to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), HSAG.

In order to evaluate the RAEs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 compliance review activities for CCHA. 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 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D 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.[3-1]

[3-1] 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 8, 2023.

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance 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 V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. 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 January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key RAE personnel to determine compliance with applicable 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 D contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2023–2024 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 III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT); 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 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, timeliness, and accessibility of 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.

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

FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with CCHA until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Related to Standard I—Coverage and Authorization of Services, CCHA was required to completed two required actions:

- Update its BH Provider Manual, peer-to-peer desktop process, UM workflow, UM program description, UM review desktop procedure, letter desktop procedure, and any related policies and procedures to clarify that the peer-to-peer process must occur prior to issuing the member a notice of adverse benefit determination (NABD). CCHA should consider enhancing these same policies, procedures, and workflows to better define instances in which staff members could consider and use extensions.
- Revise its NABD templates and letter writing procedure for substance use disorder (SUD) requests to include information about all dimensions and enhance its oversight and monitoring to ensure accurate letters for members.

Related to Standard II—Adequate Capacity and Availability of Services, HSAG identified no required actions for this standard.

Related to Standard VI—Grievance and Appeal Systems, CCHA was required to complete nine required actions:

- Enhance its messaging to members in a way that encourages members to express grievances freely without the barrier of a perceived second "formal" step. Additionally, CCHA must update and conduct a refresher training that reiterates the enhanced messaging to members who are expressing dissatisfaction.
- Develop a refresher training about how to handle additional information received by the member. CCHA must monitor staff member documentation to ensure that representatives are taking down

additional information from any member who calls to give more information on an open case. Staff members should not direct members to file a new grievance unless it is a different grievance, unrelated to the current open case.

- Update the PDF located on the CCHA website to accurately state that a grievance acknowledgement letter will be sent to the member within two working days.
- Update the PDF located on the CCHA website to remove the statement that a verbal appeal must be followed up with a written appeal. CCHA must also update its appeal acknowledgement letters to remove any requirement that the member must follow up with a verbal appeal in writing.
- Ensure that all appeal acknowledgement letters accurately identify the correct time frame for the resolution of an appeal.
- Update the member appeals policy to include that a member may file a grievance if they disagree with the appeal decision.
- Enhance its policies, procedures, and training for staff members to ensure that when an extension is in the best interest of a member, an extension letter is sent to the member and they are given prompt oral notice of the delay.
- Update the appeal resolution letter to include the RAE's contact phone number and remove "written" from its language under the "Who to contact" portion of the appeal resolution letter with regard to continuation of benefits.
- Update its BH Provider Manual to include the following:
  - Remove "appeal" from the last section of page 48 and relocate the three bullet points under "Grievances."
  - Remove the word "must" on page 49 regarding requiring the member to attach documents. CCHA can enhance this sentence by saying "can" or "may" or adding that the member can call, fax, email, or mail documentation.
  - On page 52, include the language, "For notice of an expedited resolution, the Contractor must also *make reasonable efforts to provide oral notice of resolution*."

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions for this standard.

Summary of Corrective Action/Document Review

CCHA submitted a proposed CAP in July 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to CCHA. CCHA submitted final documentation and completed the CAP in December 2023.

Summary of Continued Required Actions

CCHA successfully completed the FY 2022–2023 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* RAE Contract: Exhibit B-8—7.2.5 and 7.2.7.9	The following document outlines the language and accessibility requirements as they relate to member materials, including CCHA's requirement for member testing and its definition of large-scale communications. • V.MI.01_CCHA_Member and Provider Materials and Website Policy, Page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* RAE Contract: Exhibit B-8—7.3.8.1	The Health First Colorado website contains valuable information for members regarding their benefits under Medicaid and any cost sharing requirements. • https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook The CCHA website contains information about the benefits and services that CCHA provides. • https://www.cchacares.com/for-members/member-benefits-services/ CCHA's Frequently Asked Questions webpage includes answers to common questions about benefits, services, and requirements of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• https://www.cchacares.com/for-members/frequently-asked-questions/ The following documents outline the services CCHA provides to members and how to access services. • V.MI.02_CCHA Map to Medicaid_ENG, entire document • V.MI.02_CCHA_Map to Medicaid_SP, entire document • V.MI.02_CCHA_Health First Colorado FAQ, entire document The following documents describe how the Member Support Services team assists members to understand their benefits and access services. • V.MI.02_CCHA Program Description_Member Support Services, entire document • V.MI.02_CCHA Member Support Services Policy, entire document • V.MI.02_CCHA Member Benefits Assessment, entire document CCHA produced an American Sign Language (ASL) Interpreted Medicaid Benefits and Services Webinar to educate members who are d/Deaf or hard-of-hearing about Medicaid benefits and services and how CCHA can help. • https://www.cchacares.com/ASLMedicaid	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* RAE Contract: Exhibit B-8—3.6	Although this requirement is not applicable, CCHA has included this requirement in the following policy to ensure compliance with federal and contractual requirements. • V.MI.03_CCHA_Member and Provider Materials and Website Policy, pg. 2 The following document is an example of a member communication notice that is modeled after the HCPF template. • V.MI.03_Notice of Adverse Benefit Determination ENG • V.MI.03_Notice of Adverse Benefit Determination SPN	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.	The following document contains all information from this requirement, including the definition of prevalent non-English languages that are present in CCHA's service regions. • V.MI.04_CCHA_Member and Provider Materials and Website Policy, pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(2-3) and (d)(6)* RAE Contract: Exhibit B-8—7.2.7.3-9 and 7.3.13.3	The following document provides a visual overview of the member testing process. • V.MI.04_CCHA Member Testing Process, entire document All pages on CCHA's website include instructions on how to receive information in alternative formats. CCHA also provides links to the Health First Colorado Member Handbook via the Member Benefits and Services and FAQ pages. • https://www.cchacares.com/ The CCHA Provider Directory allows members to copy, print or export into CSV, Excel, or PDF a copy of the directory, as well as information on how to request a paper version or alternative format from Member Support Services. • https://www.cchacares.com/for-members/find-a-provider/ CCHA developed the following document to train staff and some community partners on how to use the online CCHA Provider Directory. • V.MI.04_CCHA Provider Search Guide, entire document The following notice of adverse benefit determination letter is the CCHA version of the state developed template that is sent to a member when CCHA makes an adverse benefit	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	determination, which complies with all language requirements. • V.MI.04_Notice of Adverse Benefit Determination ENG • V.MI.04_Notice of Adverse Benefit Determination SPN • V.MI.04_Medical Necessity Uphold Letter ENG_tracked changes • V.MI.04_Medical Necessity Uphold Letter SP_tracked changes • V.MI.04_Member Appeal Partial Med Nec Uphold Letter ENG_tracked changes • V.MI.04_Member Appeal Partial Med Nec Uphold Letter SPN_tracked changes The following documents are examples of letters sent to members which comply with all information requirements. • V.MI.04_Member Complaint Acknowledgement Letter ENG, entire document • V.MI.04_Member Complaint Acknowledgement Letter SP, entire document • V.MI.04_Member Complaint Resolution NON QOC Letter ENG • V.MI.04_Member Complaint Resolution QOC Letter ENG	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.04_Member Complaint Resolution NON QOC Letter SP • V.MI.04_Member Complaint Resolution QOC Letter SP • V.MI.04_Notice of Adverse Benefit Determination ENG • V.MI.04_Notice of Adverse Benefit Determination SPN • V.MI.04_Member Appeal Ack Verbal Letter ENG • V.MI.04_Member Appeal Ack Verbal Letter SP • V.MI.04_Member Appeal Ack Written Letter ENG • V.MI.04_Member Appeal Ack Written Letter SP • V.MI.04_Member Appeal Past Timely Filing Letter ENG • V.MI.04_Member Appeal Past Timely Filing Letter SP • V.MI.04_Member Appeal Admin Uphold Letter ENG • V.MI.04_Member Appeal Admin Uphold Letter ENG • V.MI.04_Member Appeal Time Frame Extension Letter ENG • V.MI.04_Member Appeal Time Frame Extension Letter SPN	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.04_Member Appeal Medical Necessity Uphold Letter ENG • V.MI.04_Medical Necessity Uphold Letter SP_tracked changes • V.MI.04_Member Appeal Overturn Letter ENG • V.MI.04_Member Appeal Overturn Letter SP • V.MI.04_Member Appeal Withdrawal Letter ENG • V.MI.04_Member Appeal Withdrawal Letter SP CCHA developed the following document to provide guidance on required elements when creating written communication to members. • V.MI.04_CCHA Member Information Requirements Guidance The following documents are examples of written communication to members that meet all elements of this requirement. • V.MI.04_CCHA Well Child Insert_ENG • V.MI.04_CCHA Well Child Insert_SP	

Standard V—Member Information Requirements		
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. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* RAE Contract: Exhibit B-8—7.3.9.2 and 7.3.14.1	The following policy includes the criteria outlined in this requirement for member information that is made available electronically. • V.MI.05_CCHA_Member and Provider Materials and Website Policy, pg. 4-5 All pages on the CCHA website include instructions on how to receive information in alternative formats, and that information will be provided in paper form free of charge within five business days. • https://www.cchacares.com • https://www.cchacares.com/for-members/member-benefits-services/ • V.MI.05_CCHA _Get Help screenshot, entire document The following documents includes the criteria outlined in this requirement for member information that is made available through printed media and demonstrate how CCHA tracks timeliness. • V.MI.05_CCHA Member Request for Printed Material Timeliness Tracking Procedure, entire document • V.MI.05_CCHA Mail Tracking Sample Audit, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA's Member Benefits and Services webpage provides links to the Health First Colorado website via the "Learn more about Health First Colorado benefits" and "Get your Health First Colorado Member Handbook" buttons. • https://www.cchacares.com/for-members/member-benefits-services	
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)(i)* RAE Contract: Exhibit B-8—None	CCHA's Frequently Asked Questions webpage provides a link for members to the Health First Colorado Pharmacy Benefits page under the "What prescription drugs does Health First Colorado Cover?" section for the most up to date information. CCHA does not produce its own formulary as it does not manage the prescription drug benefit. • https://www.cchacares.com/for-members/frequently-asked-questions/	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* RAE Contract: Exhibit B-8—7.2.6.2-4	The following policy outlines CCHA's requirements as related to oral interpretation services and availability of written translation. • V.MI.07_CCHA_Member and Provider Materials and Website Policy, pg. 3 Information regarding interpretation services and auxiliary aids is provided to behavioral health providers via the Provider Manual.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.07_CCHA BH Provider Manual pgs. 8, 74-75, 105 Information regarding interpretation services and auxiliary aids is provided to physical health providers via the Provider Manual. • V.MI.07_CCHA Physical Health Provider Manual, pgs. 3, 26-27. • V.MI.07_Use of Auxiliary Aids Desktop Guide The following CCHA webpages inform members they have access to oral interpretation services and how to request such services. • https://www.cchacares.com/for-members/frequently-asked-questions/ The following policy outlines the process by which CCHA facilitates language assistance services. • V.MI.07_Language Assistance Services Policy, entire document The following documents outline the process of requesting interpretation services. • V.MI.07_CCHA Interpretation for Deaf and Hard of Hearing Desktop Guide, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.07_Spoken and Written Language Interpretation Desktop Guide, entire document • V.MI.07_Use of Auxiliary Aids Desktop Guide, entire document The following reports demonstrate how CCHA reports activities around this requirement to HCPF: • V.MI.07_CCHA Language Assistance Services Report_R6, entire document	
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. RAE Contract: Exhibit B-8—7.2.6.1 and 7.2.6.4	The following policy addresses CCHA's policy to ensure language assistance is provided to members. • V.MI.08_CCHA Member and Provider Materials and Website Policy, pg. 3 The following policy outlines that CCHA shall facilitate the provision of language assistance services. • V.MI.08_CCHA Language Assistance Services Policy, pg. 2 The following policy outlines expectations for staff and provider competency regarding culturally and linguistically appropriate services (CLAS). • V.MI.08_CCHA CLAS Policy, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CCHA communicates these requirements to behavioral health providers via the Provider Manual. • V.MI.08_CCHA BH Provider Manual, pgs. 8, 74-75, 105 CCHA communicates these requirements to physical health providers via the Provider Manual. • V.MI.08_CCHA Physical Health Provider Manual, pgs. 26-27 The following document shows examples of how members can request language assistance services. • V.MI.08_CCHA Languages Insert The document below describes CCHA's overall approach to providing and ensuring language access to our members: • V.MI.08_CCHA Language Assistance Services Report_R6, entire document	
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)* RAE Contract: Exhibit B-8—7.3.8.1	Not applicable. CCHA does not produce a member handbook; however, links to the Health First Colorado Member Handbook are available on the following CCHA web pages: • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/get-help	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* RAE Contract: Exhibit B-8—7.3.8.2.2	CCHA has not had a significant change in contact information that would impact the member handbook since plan inception, so we have not had to submit this deliverable. However, should this occur, we would submit notification to The Department as per other deliverables that are initiated by a specific event (such as a change in key personnel).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook. *42 CFR 438.10* RAE Contract: Exhibit B-8—7.3.9.2	Not applicable. CCHA does not produce a member handbook; however, links to the Health First Colorado Member Handbook are available on the following CCHA web pages: • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/get-help	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* RAE Contract: Exhibit B-8—7.3.10.1	The following policy outlines CCHA's policy regarding the notification of members when a provider or practice leaves the network. • V.MI.12_CCHA Notice of a Provider Termination or Practice Closure Policy, pg. 2 The following document outlines the process for notifying members when a PCMP is terminated from the CCHA network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.12_CCHA PCMP Network Disaffiliation Procedure, entire document The following letter is sent to members when their PCMP or physical health practice is closing or leaving the CCHA network, and is available in English and Spanish. • V.MI.12_CCHA Practice Closure Template (Announcing Closure)_ENG, entire document • V.MI.12_CCHA Practice Closure Template (Announcing Closure)_SP, entire document The following letter is sent to members when their PCMP or physical health practice has closed or has left the CCHA network, and is available in English and Spanish. • V.MI.12_CCHA Office Closure Member Letter Template • V.MI.12_CCHA Practice Closure Member Letter Template_ENG, entire document • V.MI.12_CCHA Practice Closure Member Letter Template_SP, entire document The following letter is sent to members when their behavioral health provider leaves the CCHA network, and is available in English and Spanish.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.12_CCHA Practice Closure Member Letter Template_ENG • V.MI.12_CCHA Practice Closure Member Letter Template_SP	
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • The RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory. • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. RAE Contract: Exhibit B-8—7.3.9	The following policy outlines CCHA's website requirements. • V.MI.13_CCHA Member and Provider Materials and Website Policy, pg. 5 CCHA's website contains all of the requisite information as follows. RAE's contact information: • https://www.cchacares.com/about-ccha/contact-us • https://www.cchacares.com/for-members/member-assistance Member rights and handbooks: • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/frequently-asked-questions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Training for members: • Health Topics Library • https://www.cchacares.com/aslmedicaid Provider directory: • https://www.cchacares.com/for-members/find-a-provider Access to care standards: • https://www.cchacares.com/for-members/frequently-asked-questions Health First Colorado Nurse Advice Line: • https://www.cchacares.com/for-members/contact-information-resources • https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/get-help Colorado Crisis Services information: • https://www.cchacares.com/for-members/contact-information-resources • https://www.cchacares.com/for-members/options	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• https://www.cchacares.com/behavioralhealth A link to the Department's website for standardized information such as member rights and handbooks: • https://www.cchacares.com/for-members/member-benefits-services • https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/appeals-and-grievances	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies (and for RAE 1, behavioral health 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 members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.	CCHA's Provider Directory is updated daily, and contains the following provider-attested information on contracted network providers: • The name and practice name, street address, telephone number, website (if available) • Whether the provider is accepting new patients • Languages spoken and whether the provider has completed cultural competency training • Provider or practice type (search by specialty)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information. *42 CFR 438.10(h)(1-3)* RAE Contract: Exhibit B-8—7.3.9.1.6-8	• Whether the provider's office has accommodations for members with disabilities • If a member would like a paper version of the directory or the directory in a different format, they can download and print a copy using the search function. Likewise, they can call CCHA Member Support Services and a paper version will be provided free of charge upon request. • https://www.cchacares.com/for-members/find-a-provider	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* RAE Contract: Exhibit B-8—7.3.9.1.9	The CCHA Provider Directory can be exported into CSV, Excel, and PDF formats, with the option to copy or print. • https://www.cchacares.com/for-members/find-a-provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The RAE's single toll-free customer service phone number. • The RAE's email address. • The RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP).	The following document serves as a CCHA member guide for Health First Colorado members and includes information on how to contact CCHA and Health First Colorado benefits and services. It is available in both English and Spanish. • V.MI.16_CCHA Map to Medicaid_ENG, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • https://www.cchacares.com/for-members/get-help	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. • A directory of 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. RAE Contract: Exhibit B-8—7.3.6.1	The following insert provides information for members regarding CCHA's care coordination services and is available in English and Spanish. • V.MI.16_CCHA Care Coordination Insert_ENG, entire document • V.MI.16_CCHA Care Coordination Insert_SP, entire document • https://www.cchacares.com/for-members/connect-with-a-care-coordinator The following insert provides information for members regarding Health First Colorado dental benefits and is available in English and Spanish. • V.MI.16_CCHA Dental Insert, entire document • https://www.cchacares.com/dental The following document provides members with contact information for CCHA, Health First Colorado Nurse Advice Line, and Colorado Crisis Services. It is available in English and Spanish. Similar information is available on the website via the link below. • V.MI.16_CCHA ER Handout_ENG, entire document • V.MI.16_CCHA ER Handout_SP, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CCHA | Contact Information & Resources (cchacares.com) • https://www.cchacares.com/for-members/options The following insert is used to inform members that they can request assistance with transportation and is available in English and Spanish. Similar information is available on the website via the link below. • V.MI.16_CCHA Transportation Insert, entire document • https://www.cchacares.com/for-members/transportation The following document for members serves as a quick reference guide to behavioral health services and is available in English and Spanish. • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document • https://www.cchacares.com/for-members/substance-use-disorder-treatment-benefits CCHA's single toll-free customer service phone number is listed on:	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CCHA website Contact Us page • All member facing print materials, a sample of which includes: • V.MI.16_CCHA Map to Medicaid_ENG, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document • V.MI.16_CCHA ER Handout_ENG • V.MI.16_CCHA ER Handout_SP • All member correspondence CCHA's email address can be found on: • CCHA website Contact Us page CCHA's website address can be found on: • All member facing print materials, a sample of which includes: • V.MI.16_CCHA Map to Medicaid_ENG, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.16_CCHA ER Handout_ENG • V.MI.16_CCHA ER Handout_SP 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, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document • V.MI.16_CCHA ER Handout_ENG • V.MI.16_CCHA ER Handout_SP • All member correspondence The basic features of CCHA's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP) are available on: • CCHA website Member Benefits & Services page: CCHAcares.com/benefits • CCHA website Connect with a Care Coordinator page: • CCHAcares.com/carecoordinator	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• CCHA website Frequently Asked Questions page: • CCHAcares.com/faq • Member facing print materials including: • V.MI.16_CCHA Map to Medicaid_ENG, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document Which populations are subject to mandatory enrollment into the Accountable Care Collaborative is located on: • CCHA website Frequently Asked Questions page: • CCHAcares.com/faq The service area covered by CCHA is included on: • CCHA website About Us CCHAcares.com/about-ccha/ccha-health-first-colorado/ • CCHA website Member Benefits & Services page: CCHAcares.com/benefits • CCHA website Frequently Asked Questions page: • CCHAcares.com/faq	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member facing print materials including: • V.MI.16_CCHA Map to Medicaid_ENG, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document 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 • CCHA & Health First Colorado CCHA website Member Frequently Asked Questions page Member facing print materials including: • V.MI.16_CCHA Map to Medicaid_ENG, entire document • V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document	

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.16_CCHA Map to Medicaid_SP, entire document • V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document • V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document CCHA informs members via the Frequently Asked Questions page that CCHA does not restrict or limit any services because of moral or religious objections, and that if their provider will not provide a covered service due to such objections, they may contact CCHA Member Support Services. Additionally, this page informs stakeholders of member satisfaction results from the Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey conducted for 2020/2021. • CCHA | Frequently Asked Questions (cchacares.com)	
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with	The following document outlines CCHA's policy for providing information to members, as included in this requirement. Once a member provides their consent to have information submitted electronically, this is noted in CCHA's care coordination tool, Essette, for future reference. • V.MI.17_CCHA_Member and Provider Materials and Website Policy, pg. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* RAE Contract: Exhibit B-8—None	The following document outlines CCHA's policy regarding communicating with members via email or text message. • V.MI.17_CCHA_Patient Consent for E-Mail and SMS Text Messaging Policy, entire document The following document requests consent from a member to allow CCHA staff to use email and text messaging to communicate protected health information (PHI) related to scheduling appointments, community resources, and/or any other care coordination activities that are requested. • V.MI.17_CCHA_Member Unsecured Email Consent Form_ENG, entire document • V.MI.17_CCHA_Member Unsecured Email Consent Form_SP, entire document • The following document outlines CCHA's policy related to emailing protected health information (PHI). • V.MI.17_CCHA_Emailing PHI by Workforce Members Policy, entire document The following document outlines CCHA's policy regarding the use of communication plans to establish boundaries, if deemed necessary, when communicating with members.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• V.MI.17_CCHA_Member Communication Plan Policy, entire document The following letter template is used to inform members when a communication plan is put in place and defines the specific ways in which CCHA will communicate with the member to ensure effective care coordination. • V.MI.17_CCHA_Member Communication Plan Template, entire document	
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* RAE Contract: Exhibit B-8—None	CCHA includes information about its physician incentive plans on the Frequently Asked Questions page of its website. • https://www.cchacares.com/for-members/frequently-asked-questions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	18
Total Score ÷ Total Applicable						=	100%

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract: Exhibit B-8—9.1.6	The following documents outline selection and retention policies and procedures for CCHA physical health providers. • VII.PSPI.01_Request to Join Provider Network PCMP Policy, entire document • VII.PSPI.01_Processing PCMP Changes Policy, entire document • VII.PSPI.01_Adding PCMP Locations to a Group Policy, entire document • VII.PSPI.01_CCHA Physical Health Provider Manual, pg. 27 • CCHA's selection and retention criteria is posted to the public website. • https://www.cchacares.com/for-providers/provider-network-qualifications/ The following document describes how CCHA recruits and contracts with new providers and applicable circumstances for recruiting new providers to join its network. • VII.PSPI.01_CCHA Physical Health Recruitment Strategy, entire document • VII.PSPI.01_CCHA Annual BH Recruitment Strategy, entire document • VII.PSPI.01_CCHA Provider Network Qualifications	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following documents outline which provider types CCHA contracts with and ensures an adequate network to meet the needs of members. • VII.PSPI.01_CCHA Provider Network Adequacy and Access Standards Policy, entire document • VII.PSPI.01_CCHA ADA Compliance for Participating Providers Policy, entire document The following document outlines the policy and procedures for credentialing behavioral health providers into CCHA's network. Elevance manages the credentialing and recredentialing process for CCHA. • VII.PSPI.01_CCHA Credentialing Policy, entire document The following documents outline CCHA's network management strategies that aid in provider retention in Region 6. • VII.PSPI.01_Network Management Strategic Pln_FY23-24_R6, entire document • VII.PSPI.01_Network Management Strategic Pln HCPF Response_FY23-24_R6, entire document	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). • The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b)* RAE Contract: Exhibit B-8—9.3.5.2.1 and 9.3.6	The following document outlines CCHA's credentialing and recredentialing process for behavioral health providers, which follows NCQA standards. • VII.PSPI.02_CCHA Credentialing Policy, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract: Exhibit B-8—9.1.6.1-2	The following documents outline the non-discrimination policies as they apply to physical health providers. • VII.PSPI.03_Request to Join Provider Network - PCMP Policy, p. 2 • VII.PSPI.03_CCHA Physical Health Provider Manual Chapter 7 The following section of the provider manual outlines the rights of CCHA behavioral health providers, including the right to not be discriminated against for acting within the scope of their licensure, as well as the right to not be discriminated against for treating certain populations of CCHA members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.03_CCHA BH Provider Manual p. 79 The following document outlines the non-discrimination policy for CCHA's Credentialing program. • VII.PSPI.03_CCHA Credentialing Policy, p. 4	
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract: Exhibit B-8—9.1.6.4, 9.1.9, and 14.4.11	The following document states that CCHA will notify providers in writing if CCHA declines to include an individual provider or group in its PCMP network. • VII.PSPI.04_CCHA PCMP License Screening Process, p. 2 The following document demonstrates how CCHA documents when a provider's request to join the PCMP network is denied. • VII.PSPI.04_CCHA RTJ Denial Tracker, entire document The following document provides an example of the written notification a provider would receive if CCHA were to decline their request to join the PCMP network, stating the reason for CCHA's decision. • VII.PSPI.04_CCHA Denial for License Issues Template Letter, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.04_Initial Denial Letter (Both R6 and R7) • VII.PSPI.04_Business Denial Letter (Both R6 and R7) • VII.PSPI.04_Initial Denial Letter (Both R6 and R7) The following section of the Credentialing Policy outlines how CCHA notifies BH providers of the decision to decline or terminate participation in CCHA's network. • VII.PSPI.04_CCHA Credentialing Policy, entire document	
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract: Exhibit B-8—9.1.13	The following documents are the standard contract templates that CCHA uses to contract with physical health providers in its network. • VII.PSPI.05_CCHA PCMP Agreement Template, entire document • VII.PSPI.05_CCHA ACN Agreement Template, entire document The following document includes a statement that PCMPs must sign agreements. • VII.PSPI.05_CCHA Physical Health Provider Manual, Chapter 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following documents outline how CCHA audits contracted physical health providers and notifies internal and external staff of changes. • VII.PSPI.05_Kchecks User Guide, entire document • VII.PSPI.05_Contract Notifications Procedure, entire document The following document is the template base contract CCHA uses to contract with providers. • VII.PPPI.05_CO RAE BH Contract Template entire document The following documents provide evidence that CCHA enters into signed contracts with each provider in the R6 network. • VII.PSPI.05_Network Management Strategic Pln HCPF Response_FY23-24_R6, Section (1), entire document • VII.PSPI.05_Network Management Strategic Pln HCPF Response_FY23-24_R6, entire document	
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS OIG's List of Excluded Individuals.	The following document states that CCHA will not employ or contract with anyone excluded from participation in federal or state health care programs and outlines procedures for monitoring against OIG. • VII.PSPI.06_Excluded Individuals and Entities Policy, p. 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(This requirement also requires a policy.) *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract: Exhibit B-8—9.1.15 and 17.10.5	The following document demonstrates that CCHA does not employ or contract with providers excluded from participation in federal or state health care programs and outlines the procedure to verify provider eligibility against the OIG List of Excluded Individuals. • VII.PSPI.06_Request to Join Provider Network PCMP Policy, p. 2 The following policy demonstrates providers who are excluded from participation are immediately denied. • VII.PSPI.06_PCMP License Screening Process, p. 1 The following document includes a statement that CCHA does not employ or contract with providers excluded from participation in federal or state health care programs and outlines the procedure to verify provider eligibility. • VII.PSPI.06_CCHA Physical Health Provider Manual, Chapter 7 The following contract templates include a statement that the signing entity it is not an excluded provider and will notify CCHA if it receives notice that is excluded. • VII.PSPI.05_CCHA PCMP Agreement Template, p. 14	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.05_CCHA ACN Agreement Template, p. 14 The following document outlines the process by which providers are continuously monitored on the listed government agencies websites for exclusion of participation. • VII.PSPI.06_Kchecks User Guide, p. 1 The following documents include logs of potential matches to providers in the CCHA system during the monthly KChecks monitoring, which are then resolved or verified in the Notes Report. • VII.PSPI.06_KChecks Matches, entire document • VII.PSPI.06_KChecks Notes Report, entire document The following sections speak to CCHA's requirement to not credential or recredential any behavioral health applicant that is sanctioned/debarred/excluded from participation in federal health care programs, as well as CCHA's monthly monitoring of the LEIE. • VII.PSPI.06_Credentialing Policy, p. 10, 13, 30-31	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following section of the policy confirms CCHA's requirement to not contract with excluded providers during the provider recruitment process. • VII.PSPI.06_CCHA Annual BH Recruitment Strategy, p. 1-2	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract: Exhibit B-8—17.9.4.2.3	The following section of the policy reflects CCHA's requirement to not knowingly have an excluded director, partner, officer, subcontractor, employee, consultant, or owner/beneficial owner. • VII.PSPI.07_Excluded Individuals and Entities Policy, p. 2 and 4 The following documents are CCHA's required Ownership and Control Disclosure submission for Region 6 where CCHA attests to not knowingly having an excluded director, partner, officer, subcontractor, employee, consultant, or owner/beneficial owner. • VII.PSPI.07_CCHA Ownership and Control Disclosure FY23-24_R6, entire document • VII.PSPI.07_CCHA Ownership and Control Disclosure FY23-24 Attachment_R6, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract: Exhibit B-8—14.7.3	The following section of the provider manual confirms that CCHA BH providers will not be prohibited or restricted by CCHA for advocating on behalf of their patients. • VII.PSPI.08_CCHA BH Provider Manual p. 79 The following document includes a similar statement for physical health providers. • VII.PSPI.08_CCHA Physical Health Provider Manual, p. 33	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment.	Not Applicable. CCHA does not object to providing any covered service on the basis of moral or religious grounds, so this item is deemed to be non-applicable. However, if CCHA becomes aware of a situation where a network provider wishes to not provide such services, CCHA will support the member as indicated in the following documents:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* RAE Contract: Exhibit B-8—7.3.6.1.13-14 and 14.4.8	• VII.PSPI.09_CCHA Provider Network Adequacy and Access Standards Policy • VII.PSPI.09_CCHA Advance Directives Policy, p. 2 • VII.PSPI.09_CCHA Physical Health Provider Manual, p. 14 • VII.PSPI.09_Member Rights and Responsibilities Policy, p. 2 • https://www.cchacares.com/for-members/frequently-asked-questions	
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the	The CCHA Compliance Plans speak to the overall Compliance Program, including the Code of Conduct, supporting policies and procedures, designation of the Plan Compliance Officer, the Compliance Committee's roles and responsibilities, and training and communication of applicable staff. • VII.PSPI.10_CCHA Compliance Plan_FY23-24_R6, entire document • VII.PSPI.10_CCHA Compliance Plan_FY23-24_R7, entire document. Compliance plan mirrors the R6 plan. The R6 plan is annotated As CCHA is a joint venture between Elevance Health and Physician Health Partners (PHP), employees from both companies work for and on behalf of CCHA. The Codes of Conduct from both Elevance and PHP are provided that demonstrate the standards of conduct and commitment to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7	comply with all applicable laws and policies and procedures. • VII.PSPI.10_Elevance Code of Conduct, entire document • VII.PSPI.10_PHP Code of Conduct, entire document The following policy outlines how Compliance performs and refers internal investigations of Compliance issues, including the disciplinary measures an associate may experience due to the outcome of an investigation. • VII.PSPI.10_Compliance Investigations Policy, page 2 • VII.PSPI.10_Elevance Code of Conduct, page 9 The following document outlines how Compliance performs routine monitoring and enacts audit plans. • VII.PSPI.10_Compliance Monitoring and Auditing Policy, entire document The following documents all support CCHA's Compliance Plan and our adherence. • VII.PSPI.10_Reporting of Fraud Abuse Investigations Policy, entire document • VII.PSPI.10_CCHA Provider Payment Suspension Policy, entire document	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.10_CCHA Provider Termination with Cause Policy, entire document. • VII.PSPI.10_CCHA Member Verification of Services Policy, entire document • VII.PSPI.10_CCHA Reporting Change in Member Circumstance Policy, entire document • VII.PSPI.1_CCHA Credentialing Policy, entire document • VII.PSPI.6_CCHA Excluded Individuals and Entities Policy, entire document • VII.PSPI.10_Antifraud Plan, entire document • VII.PSPI.10_CCHA Member Verification of Services Policy • VII.PSPI.10_ElevanceHealth_SIU_Antifraud_Plan_CO_Government(Both Regions 6&7)_Entire document • VII.PSPI.10_Investigations of Suspected Fraud and Abuse (Both Regions 6&7)_Entire document • VII.PSPI.10_Provider Payment Suspension Policy • VII.PSPI.10_Reporting of Fraud and Abuse Investigations (Regions 6&7)_Entire document	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23). *42 CFR 438.608(a)(6-8)* RAE Contract: Exhibit B-8—17.1.5.9, 17.1.6, 17.5.1, and 17.7.1 10 CCR 2505-10, Section 8.076	The following documents apply to PHP employees who work for or on behalf of CCHA. • VII.PSPI.11_PHP False Claims Act Policy, entire document • VII.PSPI.11_PHP Fraud Waste and Abuse Policy, entire document • VII.PSPI.11_PHP FWA Training Attestation 2023, entire document The following document includes detailed information about the False Claims Act, including nonretaliation protections for reporters, where to report suspected violations directly, and provisions for suspension of payments. • VII.PSPI.1_CCHA Physical Health Provider Manual, p. Chapter 6 The following document provides evidence that provisions are in place to suspend payments for physical health network providers when directed to do so by the state. • VII.PSPI.11_Provider Payment Suspension - CO (Both Regions 6 and 7), entire document • VII.PSPI.11_PH Provider Payment Suspension Policy The following documents outline the operations and processes of the Elevance Special	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Investigations Unit, which includes developing and maintaining relationships with the State Medicaid Fraud Control Unit. • VII.PSPI.10_Antifraud Plan, entire document • VII.PSPI.11_2023 National Payment Integrity Plan_CO (Both Region 6 and 7) • VII.PSPI.11_Member Verification of Services-CO The following policy provides guidance for the False Claims Act to Elevance employees, including whistleblower protections and non-retaliation policy. • VII.PSPI.11_Fraud Waste and Abuse Detection and Prevention in Health Plan Operations Policy, entire document The following section of the Program Integrity Plan outlines how Compliance and Program Integrity work together to enforce associate compliance with state and federal laws, including the Deficit Reduction Act of 2005. • VII.PSPI.11_Program Integrity Plan, p. 27 The following policy outlines the procedure Compliance follows when HCPF notifies CCHA to suspend payments to a behavioral health provider due to credible allegations of fraud.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.11_Provider Payment Suspension - CO (Both Regions 6 and 7) The following policy outlines the requirements for reporting suspected fraud, waste, and abuse to the appropriate State agencies by Elevance's SIU. • VII.PSPI.11_Reporting of Fraud and Abuse Investigations(Regions 6&7)_Entire document The following is the form CCHA uses to notify HCPF and the MFCU of suspected provider fraud. • VII.PSPI.11_MCO Suspected Provider Fraud Written Notice Form eff20221114(Regions 6&7)_Entire document	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.	The following document outlines the procedure to notify the state when a physical health network provider is terminated from the CCHA network or closes their practice. • VII.PSPI.12_CCHA Notice of a Provider Termination or Practice Closure Policy The following document outlines the procedure to notify the State when a network provider is terminated from the CCHA physical health network. • VII.PSPI.12_PCMP Network Disaffiliation Procedure, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract: Exhibit B-8—17.1.5.7.1, 17.1.5.7.2-6, 17.3.1.1.2.3-4, and 17.3.1.3.1.1	The following documents include CCHA's procedure and template to notify the state when there is a change in a member's circumstance that may affect the member's eligibility, including change in member residence and death. • VII.PSPI.12_CCHA Reporting Change In Member Circumstance Policy, entire document • VII.PSPI.12_CCHA Change in Member Circumstance Sample Report_R6, entire document • VII.PSPI.12_CCHA Change in Member Circumstance Sample Report_R7, entire document The following policy outlines how CCHA verifies members did receive services billed by their providers through claims sampling. • VII.PSPI.12_Member Verification of Services Policy, entire document The following policy describes the process for terminating a CCHA network behavioral health provider for cause, including notification to HCPF. • VII.PSPI.12_CCHA Provider Termination with Cause Policy, entire document	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following section of the policy outlines the requirements under the False Claims Act to return overpayments due to fraud to the State within under the False Claims Act to return overpayments due to fraud to the State within 60 calendar days. • VII.PSPI.12_Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations (Both Regions 6 and 7) p. 13 The following section of the Program Integrity Plan outlines the requirement of Program Integrity and SIU to report all overpayments to the appropriate agencies. • VII.PSPI.12_Program Integrity Plan-ASKUBAL3-CCHA, p. 30 The following policy outlines the process for reviewing and processing overpayments, including those related to suspected fraud. • VII.PSPI.12_Overpayments Policy (Both Regions 6&7), entire document The following documents are examples of the biannual consolidated Fraud, Waste, and Abuse reports, which are a summary of audits and overpayments, submitted suspected provider and member fraud reports, as well as member service verification notices sent during the reporting period.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.12_FWARpt_QQ-QQ FY YY-YY • VII.PSPI.12_R6_FWARpt_Q3Q4FY22-23, entire document • VII.PSPI.12_R7_FWARpt_Q3Q4FY22-23, entire document The following document is an example of our monthly submissions to HCPF that documents suspension of provider payments, overpayment recoveries, and changes in provider circumstances, including termination from CCHA's network. • VII.PSPI.12_R6 Monthly FWA Report 06-23, entire document • VII.PSPI.12_R7 Monthly FWA Report 06-23, entire document	
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected members.	The following document demonstrates CCHA's policy on excluded individuals and entities to ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements: • VII.PPPI.13_CCHA Excluded Individuals and Entities Policy, entire document The following document outlines the BH Provider recruitment Strategy: • VII.PSPI.13_CCHA Annual BH Recruitment Strategy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.608(b) RAE Contract: Exhibit B-8—9.2.1.1, 9.3.2, and 17.9.2		
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract: Exhibit B-8—17.3.1.5.1.1, 17.9.4.3, and 17.10.2.1	The following policy outlines our requirement to notify appropriate state agencies of any excluded individuals. • VII.PSPI.14_CCHA Excluded Individuals and Entities Policy, p. 3 The following policy outlines CCHA's requirement to notify HCPF of its ownership or controlling interests, as well as the procedure for submitting notifications due to changes and/or at contractually required time periods. • VII.PSPI.14_State Notification Disclosure of Change In Ownership or Controlling Interest Policy, entire document The following documents are the required state submission where CCHA provides written disclosure of any prohibited affiliations, as well as applicable ownership and control information. • VII.PSPI.14_CCHA Ownership and Control Disclosure FY23-24 R6, entire document • VII.PSPI.14_CCHA Ownership and Control Disclosure FY23-24 Attachment R6, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract: Exhibit B-8—17.1.5.8 and 17.3.1.2.4.4	The following document outlines the requirements for CCHA providers regarding overpayments. • VII.PSPI.15_CO RAE BH Contract Template, p. 4 The following section of the BH provider manual informs providers on the overpayment recovery process, including where to find applicable forms, contact information, as well as applicable laws and regulations regarding overpayments. • VII.PSPI.15_CCHA BH Provider Manual - Claims Overpayment Recovery Procedure, p. 42 The following document is an example of the first notice sent to a CCHA provider when we identify an overpayment, which includes how to return payment to CCHA and how to dispute the request. • VII.PSPI.15_Provider Overpayment Request Letter First Notice, entire document The following document is an example of the final notice sent to a CCHA provider when we identify an overpayment, which includes how to return payment to CCHA and how to dispute the request, as well as actions CCHA will take to offset the overpayment if not received.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• VII.PSPI.15_Provider Overpayment Request Letter Final Notice, entire document The following document is the biannual consolidated Fraud, Waste, and Abuse report, which is a summary of audits and overpayments, submitted suspected provider and member fraud reports, as well as member service verification notices sent during the reporting period. • VII.PSPI.15_R6_FWARpt_Q3Q4FY22-23, entire document	
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106*	The following document demonstrates that members cannot be held financially liable for services covered by Health First Colorado and be charged for scheduling appointments or missed or canceled appointments. All medically necessary covered services are offered to all members. • VII.PSPI.16_Physical Health Provider Manual, p. 12 The following newsletter articles are an example of the reminders send out to providers about members' liabilities: • VII.PSPI.16_CCHA Provider Newsletter_July 2023, P. 3 • VII.PSPI.16_CCHA Provider Newsletter_August 2023, P. 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—14.14.1-2 and 17.13.2-4	The following section of the provider manual outlines CCHA's requirements that members are not held liable for its debts and/or debts of a CCHA provider. • VII.PSPI.16_ CCHA Behavioral Health Provider Manual - Billing Members, page 40 The following section of the provider contract holds CCHA members harmless from providers seeking payment from members for Medicaid covered services. • VII.PSPI.16_CO RAE BH Contract Template	

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
Total Score ÷ Total Applicable						=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract: Exhibit B-8—4.2.13	The following document serves as the model state-specific exhibit where Elevance enters into a subcontractor agreement for work performed for CCHA. • IX.SRD.01_Colorado Subcontractor Exhibit _01.24.19 The following document is the overarching contract Elevance maintains with CyraCom to perform services on behalf of CCHA. CyraCom provides Language Interpretation Services. • IX.SRD.01_CyraCom MSA_07.14.2016 • IX.SRD.01_Cyracom MSA AM1_Price_SLA Schedule_10.28.2016 • IX.SRD.01_CyraCom MSA AM2 - Term Extension_09.14.2018 • IX.SRD.01_CyraCom SOW_Over-the-Phone Interpretation_01.04.2023 • IX.SRD.01_CyraCom MSA AM7_Term Extension_07.22.2021 The following document provides a brief overview of CyraCom's responsibilities as it relates to CCHA's contractual requirement to provide translation and interpretation services to our members. • IX.SRD.01_CyraCom Contract Summary, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following contract outlines the delegated credentialing agreement CCHA maintains with CU Medicine. • IX.SRD.01_CCHA_CU Medicine Agreement As referenced in the desk form summary, CCHA delegates care coordination activities to Accountable Care Network (ACN) providers in both regions, and two additional entities in R7, which we refer to as "rural contractors." Materials provided include monitoring mechanisms, sample performance summaries, training materials, and meeting minutes to demonstrate oversight. Executed contracts are submitted within the Miscellaneous folder, and sample contract templates are provided for subsequent requirements. The following document outlines CCHA's policy and procedure for monitoring ACN performance, and mechanisms for oversight of contracted duties. • IX.SRD.01_CCHA ACN Monitoring and Oversight Policy entire document The following document outlines CCHA's policy for assessing potential ACN candidates to determine ability to fulfill contracted care coordination activities. • IX.SRD.01_CCHA ACN Assessment Policy entire document	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines CCHA's incentive program for ACNs and establishes performance goals and mechanisms to monitor. • IX.SRD.01_ACN Provider Incentive Program entire document As outlined in contracts, ACNs are required to report member-level care coordination activities to CCHA on a monthly basis. This document outlines reporting specifications. • IX.SRD.01_ACN Care Coordination Reporting Specs entire document The following document is completed by ACNs and submitted to CCHA as part of the quarterly case audit process. • IX.SRD.01_ACN Case Audit Template entire document The following document is the action plan template used with ACNs after audits are conducted. • IX.SRD.01_ACN Action Planning Template entire document The following document provides the ACN with detailed information on earned key performance indicator (KPI) and/or value-based payment Performance Pool incentive dollars.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• IX.SRD.01_ACN KPI VBP Incentive Summary, entire document The following document is the operational policy providing an overview of how members are referred to CCHA for care coordination. • IX.SRD.01_Referral Procedures and Timeline Expectations Policy, entire document The following documents show the workflows and processes CCHA followed at the end of the Public Health Emergency (PHE) with the Continuous Enrollment Unwind (CEU) to support members with their Medicaid enrollment: • IX.SRD.01_CCHA Continuous Enrollment Unwind MSS Workflow Visual entire document • IX.SRD.01_CCHA Continuous Enrollment Unwind MSS Workflow entire document • IX.SRD.01_CE Unwind High Risk Outreach Scripting and Workflow entire document • I IX.SRD.01_PHE Continuous Enrollment Unwind PCMP Guidance, entire document The following document is used by providers and community partners to refer members in Region 6 to CCHA for care coordination. • IX.SRD.01_CCHA Referral Form_R6	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the RAE are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract: Exhibit B-8—4.2.13.6	The following document is the contract template used for our Accountable Care Network providers. • IX.SRD.02_ACN Agreement Template_2023, entire document • IX.SRD.02_Colorado Subcontractor Exhibit _01.24.19 ○ Section 1, Page 1. ○ Section 2, Page 1. ○ Section 3, Page 1. • IX.SRD.02_Aunt Bertha Agreement AM1_01.11.17 • IX.SRD.02_Aunt Bertha Agreement AM2_02.20.19 • IX.SRD.02_Aunt Bertha CRL CO SOW_02.18.2021 • IX.SRD.02_Aunt Bertha GBSA_01.05.15 • IX.SRD.02_LanguageLine MSA AM12_04.26.2021 • IX.SRD.02_LanguageLine MSA_03.30.2013 • IX.SRD.02_LanguageLine SOW OPI _VRI_05.09.21 • IX.SRD.02_MRO GBSA_04.09.2019	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.	The following templates outline the subcontractor's responsibilities to follow all applicable state and federal laws and regulations. • IX.SRD.03_ACN Agreement Template_2023, pg. 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.230(c)(2) RAE Contract: Exhibit B-8—4.2.13.6	• IX.SRD.03_Colorado Subcontractor Exhibit _01.24.19, Section 4, Page 2. • IX.SRD.03_Aunt Bertha Agreement AM1_01.11.17 • IX.SRD.03_Aunt Bertha Agreement AM2_02.20.19 • IX.SRD.03_Aunt Bertha CRL CO SOW_02.18.2021 • IX.SRD.03_Aunt Bertha GBSA_01.05.15 • IX.SRD.03_LanguageLine MSA AM12_04.26.2021 • IX.SRD.03_LanguageLine MSA_03.30.2013 • IX.SRD.03_LanguageLine SOW OPI _VRI_05.09.21 • IX.SRD.03_MRO GBSA_04.09.2019	
4. The written agreement with the subcontractor includes: • The State, CMS, the 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,	The following documents outline the subcontractor's requirements to abide by the right for government entities to inspect and audit elements that pertain to the activities performed for CCHA's contract. • IX.SRD.2_ACN Agreement Template_2023, pgs. 7-8 • IX.SRD.04_Colorado Subcontractor Exhibit _01.24.19 o Section 5, Page 2. o Section 5.ii., Page 2. o Section 6, Page 2.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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. *42 CFR 438.230(c)(3)* RAE Contract: Exhibit B-8—4.2.13.6	• IX.SRD.04_Aunt Bertha Agreement AM1_01.11.17 • IX.SRD.04_Aunt Bertha Agreement AM2_02.20.19 • IX.SRD.04_Aunt Bertha CRL CO SOW_02.18.2021 • IX.SRD.04_Aunt Bertha GBSA_01.05.15 • IX.SRD.04_LanguageLine MSA AM12_04.26.2021 • IX.SRD.04_LanguageLine MSA_03.30.2013 • IX.SRD.04_LanguageLine SOW OPI _VRI_05.09.21 • IX.SRD.04_MRO GBSA_04.09.2019	
Findings: HSAG reviewed a sample of contracts across the delegated activities and found that some of the written agreements did not include the required language.		
Required Actions: CCHA must ensure, via revisions or amendments, that all subcontractor agreements include the following required language: • The State, CMS, the 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.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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.		

Results for Standard IX—Subcontractual Relationships and Delegation						
Total	Met	=	3	X 1.00	=	3
	Partially Met	=	1	X .00	=	0
	Not Met	=	0	X .00	=	0
	Not Applicable	=	0	X NA	=	NA
Total Applicable		=	4	**Total Score**	=	3
Total Score ÷ Total Applicable					=	75%

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* RAE Contract: Exhibit B-8—16.1.1	The following document outlines the Peer Review process for evaluating quality incidents as part of CCHA's QAPI program. • X.QAPI.01_QOC Peer Review Process, entire document The following policy outlines CCHA's grievance process for member complaints and complaints made on behalf of members. • X.QAPI.01_Member Grievances Policy, entire document The following policy outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines. • X.QAPI.01_CCHA Quality of Care Policy entire document The following policy describes the Critical Incidents reporting process CCHA manages under its QAPI program. • X.QAPI.01_Critical Incident Reporting Policy - CO entire document The following sections of the BH and PH provider manuals outline CCHA's QAPI program for CCHA network providers. • X.QAPI.01_CCHA BH Provider Manual, pages 85-86	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document is used to assess quality and performance for behavioral health incentive program measures for behavioral health providers. • X.QAPI.01_Behavioral Health Scorecards The following documents outline the incentive program for physical health providers, aimed at improving the quality of care given to Medicaid members. • X.QAPI.01_CCHA PCMP Incentive Program, entire document • X.QAPI.01_CCHA ACN Incentive Program, entire document The following documents describe CCHA's Quality Plan • X. QAPI.01_CCHA Quality Improvement Plan_SFY23-24_R6, entire document • X.QAPI.01_CCHA Quality Report_FY22-23_R6, entire document The following document demonstrates CCHA's Key Performance Indicator (KPI) performance. • X.QAPI.01_CCHA KPI Dashboards	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one administrative and one clinical.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract: Exhibit B-8—16.2.1.1, 16.3.5, and 16.3.8	The following documents are for the BH and PH PIPs and include closeout and module submissions. • X.QAPI.02_PIP Submission Form SDOH R6, entire doc • X.QAPI.02_PIP Submission Form FUH R6 entire doc • X.QAPI.02_PIP Intervention Worksheet FUH R6, entire doc • X.QAPI.02_PIP Intervention Worksheet SDOH R6 entire doc • X.QAPI.02_PIP Validation Report R6 • X.QAPI.02_R6_New Clinical PIP Topic Selection Form • X.QAPI.02_R6_SDOH_CO2023-24 PIP Submission Form_F1 • X.QAPI.02_SDOH_R6_CO2023-24_Intervention Worksheet_F1 • X.QAPI.02_R6_CO2023-24 PIP Submission Form_F1 • X.QAPI.02_R6_CO2023-24_Intervention Worksheet_F1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State): • Annual performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract: Exhibit B-8—16.4.1 and 16.4.4	The following policy outlines how performance data is collected and submitted to HCPF. • X.QAPI.03_Performance Measurement Policy and Procedure The following document demonstrates performance data metrics using specifications provided by the state to monitor performance and implement interventions as needed in a timely manner. • X.QAPI.03_CCHA KPI Dashboards The following policy outlines how performance data is collected and submitted to HCPF. • X.QAPI.03_ECC Attestation Form_R6, entire document • X.QAPI.03_SFY 2022-2023 ECC Workbook_R6, entire document The following documents describe CCHA's Quality Plan. • X. QAPI.03_CCHA Quality Improvement Plan_SFY23-24_R6, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)*	The following policy outlines the Client Over Utilization Program. • X.QAPI.04_CC_COUP Policy, entire document The following documents demonstrate how CCHA members are reviewed for utilizing high rates of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—16.6.1	inpatient and intensive outpatient services to see which members (and their providers) would be most impacted by interventions to find more appropriate levels of care. • X.QAPI.04_CCHA Top 100 Report • X.QAPI.04_CCHA BH Facility Report The following document looks at cost per CCHA members to see where intervention for more in-depth care coordination and provider outreach would be successful. • X.QAPI.04_Member Lookup Report Screenshots, entire document • X.QAPI.04_SEP CCB Complex Case Review Referral Form, entire document The following document is an example of a Power BI dashboard used to detect underutilization. • X.QAPI.04_CCHA KPI Dashboards entire document The following document shows CCHA's plan to outreach members who are non-utilizers of the system: • X.QAPI.04_EPSDT Outreach Plan R6, Page 4	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.* *42 CFR 438.330(b)(4)* RAE Contract: Exhibit B-8—16.2.1.4 and 16.5.5 10 CCR 2505-10, Section 8.205.8	The following policy outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines. • X.QAPI.05_Quality of Care Policy, entire document The following document is a template used for Complex Case Review meetings with the SEPs and CCBs in both regions. • X.QAPI.05 Complex Case Review Referral Form, entire document The following document provides an overview of CCHA's care coordination model, which includes special populations. • X.QAPI.05_CCHA Care Coordination Model, entire document In order for Medicaid members or other stakeholders to be able to submit quality of care concerns at any point of contact with CCHA, CCHA trains its member-facing staff annually on the quality of care and grievance processes. The following documents are training materials used and attestations of training completion. • X.QAPI.05_CCHA Attestation for Grievance and QOC Training_MSS and CC, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• X.QAPI.05_CCHA R6 & R7_QOC-Grievance-Appeals Training 1.24.2023 The following documents provide an overview of the mechanisms of evaluation used to assess the care provided to Medicaid members who have contact with the Colorado Department of Corrections (DOC). • X.QAPI.05_CCHA Ascent DOC Partnership MOU, entire document The following documents provide an overview of the mechanisms of evaluation used to assess the care provided to Medicaid members who have contact with the Foster Care System • X.QAPI.05_CCHA Program Description Pediatric Foster Care, entire document • X.QAPI.05_CCHA Support for Pediatric Members with Special Health Care Needs, entire document CCHA has executed agreements with the Single Entry Points (SEPs) and Community Centered Boards (CCBs), in its regions. The following documents are examples of Memorandums of Understanding and workflows with the SEPs and CCBs, which include mechanisms to assess quality and appropriateness of care for the special populations these community entities serve.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• X.QAPI.05_CCHA MOU_ACMI • X.QAPI.05_ACMI Workflow • X.QAPI.05_ACMI Performance Pool Letter The following documents are meeting minutes summarizing meetings between CCHA and BH facilities to discuss quality of care complaints filed against the facility. • X.QAPI.05_R6 CCHA QMC Meeting Minutes 2.21.2023 • X.QAPI.05_R6 CCHA QMC Meeting Minutes 5.23.2023 • X.QAPI.05_R6 CCHA QMC Meeting Minutes 8.29.2023.	
6. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] survey RAE Contract: Exhibit B-8—16.5.1-3 and 16.5.6	The following document outlines CAHPS results and the interventions made with appropriate providers as a result. • X.QAPI.06_CCHA CAHPS Survey Findings and Interventions 2023 The following parts of the Grievance and Appeal report provide a narrative including more information for the grievances and appeals filed during the report period, including any identifiable trends. • X.QAPI.06_CO Behavioral Health Member Appeals Core Process Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

[A-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• X.QAPI.06_CO Member Grievances Policy • X.QAPI.06_Data Sharing with CMHCS • X.QAPI.06_Grievance and Appeals Report PartII RAE 6 Qtr 1 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 6 Qtr 2 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 6 Qtr 3 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 6 Qtr 4 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 7 Qtr 1 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 7 Qtr 2 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 7 Qtr 3 2022-2023 • X.QAPI.06_Grievance and Appeals Report PartII RAE 7 Qtr 4 2022-2023 • X.QAPI.06_R6_GrieveAppealRpt_Q1FY22-23 • X.QAPI.06_R7_GrieveAppealRpt_Q1FY22-23 • X.QAPI.06_R6_GrieveAppealRpt_Q2FY22-23 • X.QAPI.06_R7_GrieveAppealRpt_Q2FY22-23 • X.QAPI.06_R6_GrieveAppealRpt_Q3-FY22-23	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• X.QAPI.06_R7_GrieveAppealRpt_Q3-FY 22-23 • X.QAPI.06_R6_GrieveAppealRpt_Q4-FY 22-23 • X.QAPI.06_R7_GrieveAppealRpt_Q4-FY 22-23 The following policy outlines CCHA's grievance process for member complaints and complaints made on behalf of members, including complaints related to access issues. • X.QAPI.1_Member Grievances Policy, entire document The following document outlines call center quality metrics. • X.QAPI.06_CCHA Call Line Statistics Report_0623_R6 • X.QAPI.06_CCHA Call Line Statistics Report_0623_R7 CCHA's Member Advisory Committee (MAC) engages Medicaid members to provide feedback on its program. The following documents provide information used to recruit members. • X.QAPI.06_CCHA MAC Interest	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following document outlines the formal training process for CCHA Member Supports and Services and Care Coordination • X.QAPI.06_CCHA Attestation for Grievance and QOC Training_MSS and CC • X.QAPI.06_ QOC-GA Staff Training Attestation • X.QAPI.06_CCHA R6 & R7_QOC-Grievance-Appeals Training 1.24.2023	
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract: Exhibit B-8—16.2.5	The following documents outline CCHA's process for evaluating its Quality program. • X.QAPI.07 _CCHA Quality Report_FY22-23_R6 • X.QAPI.07_CCHA Quality Report_FY22-23_R7 The following document demonstrates that CCHA evaluates the impact and effectiveness of its program regarding its KPI performance: • X.QAPI.07 KPI Workgroup Notes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members.	The following document outlines CCHA's Clinical Practice Guidelines for BH conditions. • X.QAPI.08_CCHA BH Provider Manual, page 82 • X.QAPI.08_Clinical Practice Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract: Exhibit B-8—14.8.9.1-3	For utilization management purposes, CCHA adopts clinical criteria to apply to BH UM decisions. The following policy outlines how clinical criteria is applied to UM decisions, as well as how the criteria is adopted. • X.QAPI.08_Clinical Criteria for Utilization Management Decisions-CO	
9. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract: Exhibit B-8—14.8.9	The following document states CCHA's policy on how to disseminate Members and Providers materials and example of a Newsletter that is send out to providers: • X. QAPI.09_CCHA Member and Provider Materials and Website Policy, entire document. • X.QAPI.09_CCHA Provider Newsletter_November 2023, page 9 • X.QAPI.09_CCHA BH Provider Manual, page 82 • X.QAPI.09_Clinical Criteria for Utilization Management Decisions-CO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)*	The following policy outlines the process CCHA uses to apply clinical criteria to utilization management decisions to ensure consistency with the guidelines and across utilization management decisions. • X.QAPI.10_Clinical Practice Guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—14.8.10	• X.QAPI.8,9,10_Clinical Criteria for Utilization Management Decisions-CO • X.QAPI.9_CCHA Member and Provider Materials and Website Policy • BH Provider Manual • Website: 6Gv (cchacares.com) • X.QAPI.10_CCHA-RA-P-1276.01-EN-04.28.23 • X.QAPI.9_CCHA Provider Newsletter_November 2023	
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—15.1.1	The following document is an overview of the Management Information System Elevance utilizes on CCHA's behalf for behavioral health services. • X.QAPI.11_CO Elevance_GBD_MIS_v2.5, page 1 • X.QAPI.11_CCHA Data Flow, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B-8—8.1, 15.1.1, and 15.1.1.3.2.1	The following section outlines the areas that the Elevance MIS manages, including claims, case management, provider data, credentialing, enrollment, encounters, grievances and appeals, and program integrity. • X.QAPI.12_CO Elevance_GBD_MIS_v2.5, p. 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract: Exhibit B-8—15.2.2.3.1-2	The following diagram demonstrates how encounters are managed within Elevance's system and relayed to the State. • X.QAPI.13_CO Elevance_GBD_MIS_v2.5, p. 3 The following policy outlines the process used to submit CCHA BH encounters to the State. • X.QAPI.13_Colorado Encounters Process entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract: Exhibit B-8—15.2.2	The following section outlines which member and provider behavioral health data is maintained on behalf of CCHA. • X.QAPI.14_CO Elevance_GBD_MIS_v2.5 p. 1-2 The following policy outlines the process for reviewing, validating, and submitting encounters to the State. • X.QAPI.14_Colorado Encounters Process The following templates are examples of how CCHA collects member data.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• X.QAPI.14_Intake Assessment, entire document • X.QAPI.14_Adult HNA, entire document The following templates collect physical health provider data, both initially when requesting to join the network, and as part of the ongoing review process. • X.QAPI.14_New Practice Application Form, entire document • X.QAPI.14_New Provider Application Form, entire document • X.QAPI.14_Quality Office Systems Review Procedure	
15. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS.	The following policy outlines the process used to process claims and validate encounters. • X.QAPI.15_Colorado Encounters Process • X.QAPI.15_CO Elevance_GBD_MIS_v2.5 The following documents outline the data collected and the processes by which it is verified for physical health providers. • X.QAPI.15_New PH Practice Application Form, entire document • X.QAPI.15_New PH Provider Application Form, entire document • X.QAPI.15_Quality Office Systems Review, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.242(b)(3) and (4) RAE Contract: Exhibit B-8—15.2.2.3.1 and 15.2.2.3.6.1	• X.QAPI.15_Request to Join Provider Network - PCMP Policy, entire document • X.QAPI.15_PCMP License Screening Process, entire document • X.QAPI.15_K-Checks User Guide, entire document The following document outlines CCHA's data validation process. • X.QAPI.15_CCHA Data Flow entire document The following document outlines the data reporting specifications for member level reports reported to CCHA by the ACN. • X.QAPI.15_ACN CC Reporting Specs, entire document The following document outlines CCHA's policy and procedure for collecting and submitting performance data to the State. • X.QAPI.15_Performance Measurement Policy and Procedure	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract: Exhibit B-8—15.2.2.1-2, 15.2.2.3.2, and 15.2.2.3.4	The following document describes the requirements for CCHA's BH encounter system, including format and submission timeline after claim adjudication. • X.QAPI.16_CCHA_Encounter Data Mgmt System, p. 3 The following policy outlines the process used to submit CCHA BH encounters to the State. • X.QAPI.16_Colorado Encounters Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
Total Score ÷ Total Applicable						=	100%

Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of CCHA.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
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Crystal Brown	Project Manager I
Holly Cherry (Observer)	Project Coordinator III
CCHA Participants	**Title**
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Camila Joao	Clinical Quality Program Manager, Elevance Health
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Thomas Johnson	Director, Application Development and Data Management, Physician Health Partners

CCHA Participants	Title
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Cindi Terra	Director, Practice Transformation, Physician Health Partners
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Gina Wendling	Medicaid State Operations Director, Elevance Health
Michael Wethington	Vice President, Technical Services, Physician Health Partners
Kalena Wilkinson	Medicaid Communications Specialist, Physician Health Partners

CCHA Participants	Title
Amy Yutzy	Executive Director, Medicaid Programs, Physician Health Partners
Jessica Zaiger	Manager, Care Coordination, Physician Health Partners
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Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Lexis Mitchell	Program Specialist, Regions 6 and 7
Helen Desta-Fraser	Quality Section Manager

Appendix C. Corrective Action Plan Template for FY 2023–2024

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 C-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans 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.	

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for CCHA RAE 6

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The written agreement with the subcontractor includes: • The State, CMS, the 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. *42 CFR 438.230(c)(3)* RAE Contract: Exhibit B-8—4.2.13.6
Findings
HSAG reviewed a sample of contracts across the delegated activities and found that some of the written agreements did not include the required language.
Required Actions
CCHA must ensure, via revisions or amendments, that all subcontractor agreements include the following required language: • The State, CMS, the 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.

Standard IX—Subcontractual Relationships and Delegation
– 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.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:

Standard IX—Subcontractual Relationships and Delegation
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Appendix D. Compliance Monitoring Review Protocol Activities

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

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop 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 four 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, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the 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 FY 2023–2024 Department-approved 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.