



COLORADO

**Department of Health Care
Policy & Financing**

**Fiscal Year 2023–2024 Compliance
Review Report**
for
Colorado Community Health Alliance
Region 7

May 2024

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



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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 7 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.

2. Assessment and Findings

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 about how errors were found and addressed, CCHA staff members could describe the process to identify errors, communicate with points of contacts, and quickly resolve the errors by running documents through UserWay for validation. 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 7-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 7-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.medicare.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 complete one required action:

- 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.

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.

- 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.
- Improve monitoring of appeal acknowledgment timeliness to ensure that CCHA is meeting the time frame set forth by the State contract and federal regulations.
- 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 appeals 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.



**Appendix A. Colorado Department of Health Care Policy & Financing
FY 2023–2024 Compliance Monitoring Tool
for Colorado Community Health Alliance RAE 7**

Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>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.</p> <ul style="list-style-type: none"> The RAE ensures that all member materials (for large-scale member communications) have been member tested. <p><i>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.</i></p> <p align="right"><i>42 CFR 438.10(c)(1)</i></p> <p>RAE Contract: Exhibit B-8—7.2.5 and 7.2.7.9</p>	<p>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.</p> <ul style="list-style-type: none"> V.MI.01_CCHA_Member and Provider Materials and Website Policy, Page 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan.</p> <p align="right"><i>42 CFR 438.10(c)(7)</i></p> <p>RAE Contract: Exhibit B-8—7.3.8.1</p>	<p>The Health First Colorado website contains valuable information for members regarding their benefits under Medicaid and any cost sharing requirements.</p> <ul style="list-style-type: none"> https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook <p>The CCHA website contains information about the benefits and services that CCHA provides.</p> <ul style="list-style-type: none"> https://www.cchacares.com/for-members/member-benefits-services/ <p>CCHA’s Frequently Asked Questions webpage includes answers to common questions about benefits, services, and requirements of the plan.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



**Appendix A. Colorado Department of Health Care Policy & Financing
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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • https://www.cchacares.com/for-members/frequently-asked-questions/ <p>The following documents outline the services CCHA provides to members and how to access services.</p> <ul style="list-style-type: none"> • 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 <p>The following documents describe how the Member Support Services team assists members to understand their benefits and access services.</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <ul style="list-style-type: none"> • https://www.cchacares.com/ASLMedicaid 	



**Appendix A. Colorado Department of Health Care Policy & Financing
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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.10(c)(4)</i></p> <p>RAE Contract: Exhibit B-8—3.6</p>	<p>Although this requirement is not applicable, CCHA has included this requirement in the following policy to ensure compliance with federal and contractual requirements.</p> <ul style="list-style-type: none"> V.MI.03_CCHA_Member and Provider Materials and Website Policy, pg. 2 <p>The following document is an example of a member communication notice that is modeled after the HCPF template.</p> <ul style="list-style-type: none"> V.MI.03_Notice of Adverse Benefit Determination ENG V.MI.03_Notice of Adverse Benefit Determination SPN 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <ul style="list-style-type: none"> 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. 	<p>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.</p> <ul style="list-style-type: none"> V.MI.04_CCHA_Member and Provider Materials and Website Policy, pg. 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



**Appendix A. Colorado Department of Health Care Policy & Financing
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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> • All written materials for members must: <ul style="list-style-type: none"> – 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. <p align="right"><i>42 CFR 438.10(d)(2-3) and (d)(6)</i></p> <p>RAE Contract: Exhibit B-8—7.2.7.3-9 and 7.3.13.3</p>	<p>The following document provides a visual overview of the member testing process.</p> <ul style="list-style-type: none"> • V.MI.04_CCHA Member Testing Process, entire document <p>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.</p> <ul style="list-style-type: none"> • https://www.cchacares.com/ <p>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.</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/find-a-provider/ <p>CCHA developed the following document to train staff and some community partners on how to use the online CCHA Provider Directory.</p> <ul style="list-style-type: none"> • V.MI.04_CCHA Provider Search Guide, entire document <p>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</p>	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>determination, which complies with all language requirements.</p> <ul style="list-style-type: none"> • 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 <p>The following documents are examples of letters sent to members which comply with all information requirements.</p> <ul style="list-style-type: none"> • 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 	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • 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 	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • 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 <p>CCHA developed the following document to provide guidance on required elements when creating written communication to members.</p> <ul style="list-style-type: none"> • V.MI.04_CCHA Member Information Requirements Guidance <p>The following documents are examples of written communication to members that meet all elements of this requirement.</p> <ul style="list-style-type: none"> • V.MI.04_CCHA Well Child Insert_ENG • V.MI.04_CCHA Well Child Insert_SP 	
<p>5. <i>If the RAE makes information available electronically:</i> Information provided electronically must meet the following requirements:</p> <ul style="list-style-type: none"> • The format is readily accessible (see definition of “readily accessible” above). 	<p>The following policy includes the criteria outlined in this requirement for member information that is made available electronically.</p> <ul style="list-style-type: none"> • V.MI.05_CCHA_Member and Provider Materials and Website Policy, pg. 4-5 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.10(c)(6)</i></p> <p>RAE Contract: Exhibit B-8—7.3.9.2 and 7.3.14.1</p>	<p>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.</p> <ul style="list-style-type: none"> https://www.cchacares.com https://www.cchacares.com/for-members/member-benefits-services/ V.MI.05_CCHA_Get Help screenshot, entire document <p>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.</p> <ul style="list-style-type: none"> V.MI.05_CCHA Member Request for Printed Material Timeliness Tracking Procedure, entire document V.MI.05_CCHA Mail Tracking Sample Audit, entire document <p>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.</p>	



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	<ul style="list-style-type: none"> https://www.cchacares.com/for-members/member-benefits-services 	
<p>6. The RAE makes available to members in electronic or paper form information about its formulary:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.10(h)(4)(i)</i></p> <p>RAE Contract: Exhibit B-8—None</p>	<p>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.</p> <ul style="list-style-type: none"> https://www.cchacares.com/for-members/frequently-asked-questions/ 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right"><i>42 CFR 438.10 (d)(4) and (d)(5)</i></p> <p>RAE Contract: Exhibit B-8—7.2.6.2-4</p>	<p>The following policy outlines CCHA’s requirements as related to oral interpretation services and availability of written translation.</p> <ul style="list-style-type: none"> V.MI.07_CCHA_Member and Provider Materials and Website Policy, pg. 3 <p>Information regarding interpretation services and auxiliary aids is provided to behavioral health providers via the Provider Manual.</p> <ul style="list-style-type: none"> V.MI.07_CCHA BH Provider Manual pgs. 8, 74-75, 105 <p>Information regarding interpretation services and auxiliary aids is provided to physical health providers via the Provider Manual.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • V.MI.07_CCHA Physical Health Provider Manual, pgs. 3, 26-27. • V.MI.07_Use of Auxiliary Aids Desktop Guide <p>The following CCHA webpages inform members they have access to oral interpretation services and how to request such services.</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/frequently-asked-questions/ <p>The following policy outlines the process by which CCHA facilitates language assistance services.</p> <ul style="list-style-type: none"> • V.MI.07_Language Assistance Services Policy, entire document <p>The following documents outline the process of requesting interpretation services.</p> <ul style="list-style-type: none"> • V.MI.07_CCHA Interpretation for Deaf and Hard of Hearing Desktop Guide, entire document • V.MI.07_Spoken and Written Language Interpretation Desktop Guide, entire document • V.MI.07_Use of Auxiliary Aids Desktop Guide, entire document <p>The following reports demonstrate how CCHA reports activities around this requirement to HCPF:</p>	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> V.MI.07_CCHA Language Assistance Services Report_R7, entire document 	
<p>8. The RAE ensures that:</p> <ul style="list-style-type: none"> 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. <p>RAE Contract: Exhibit B-8—7.2.6.1 and 7.2.6.4</p>	<p>The following policy addresses CCHA’s policy to ensure language assistance is provided to members.</p> <ul style="list-style-type: none"> V.MI.08_CCHA Member and Provider Materials and Website Policy, pg. 3 <p>The following policy outlines that CCHA shall facilitate the provision of language assistance services.</p> <ul style="list-style-type: none"> V.MI.08_CCHA Language Assistance Services Policy, pg. 2 <p>The following policy outlines expectations for staff and provider competency regarding culturally and linguistically appropriate services (CLAS).</p> <ul style="list-style-type: none"> V.MI.08_CCHA CLAS Policy, entire document <p>CCHA communicates these requirements to behavioral health providers via the Provider Manual.</p> <ul style="list-style-type: none"> V.MI.08_CCHA BH Provider Manual, pgs. 8, 74-75, 105 <p>CCHA communicates these requirements to physical health providers via the Provider Manual.</p> <ul style="list-style-type: none"> V.MI.08_CCHA Physical Health Provider Manual, pgs. 26-27 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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	<p>The following document shows examples of how members can request language assistance services.</p> <ul style="list-style-type: none"> V.MI.08_CCHA Languages Insert <p>The document below describes CCHA’s overall approach to providing and ensuring language access to our members:</p> <ul style="list-style-type: none"> V.MI.08_CCHA Language Assistance Services Report_R7, entire document 	
<p>9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member’s enrollment.</p> <p align="right"><i>42 CFR 438.10(g)(1)</i></p> <p>RAE Contract: Exhibit B-8—7.3.8.1</p>	<p>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:</p> <ul style="list-style-type: none"> https://www.cchacares.com/for-members/member-benefits-services https://www.cchacares.com/for-members/get-help 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right"><i>42 CFR 438.10(g)(4)</i></p> <p>RAE Contract: Exhibit B-8—7.3.8.2.2</p>	<p>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).</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p>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).</p> <ul style="list-style-type: none"> The RAE ensures that its member handbook or supplement includes a link to the online Health First Colorado member handbook. <p align="right"><i>42 CFR 438.10</i></p> <p>RAE Contract: Exhibit B-8—7.3.9.2</p>	<p>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:</p> <ul style="list-style-type: none"> https://www.cchacares.com/for-members/member-benefits-services https://www.cchacares.com/for-members/get-help 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right"><i>42 CFR 438.10(f)(1)</i></p> <p>RAE Contract: Exhibit B-8—7.3.10.1</p>	<p>The following policy outlines CCHA’s policy regarding the notification of members when a provider or practice leaves the network.</p> <ul style="list-style-type: none"> V.MI.12_CCHA Notice of a Provider Termination or Practice Closure Policy, pg. 2 <p>The following document outlines the process for notifying members when a PCMP is terminated from the CCHA network.</p> <ul style="list-style-type: none"> V.MI.12_CCHA PCMP Network Disaffiliation Procedure, entire document <p>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.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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	<ul style="list-style-type: none"> V.MI.12_CCHA Practice Closure Template (Announcing Closure)_ENG, entire document V.MI.12_CCHA Practice Closure Template (Announcing Closure)_SP, entire document <p>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.</p> <ul style="list-style-type: none"> 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 <p>The following letter is sent to members when their behavioral health provider leaves the CCHA network, and is available in English and Spanish.</p> <ul style="list-style-type: none"> V.MI.12_CCHA Practice Closure Member Letter Template_ENG V.MI.12_CCHA Practice Closure Member Letter Template_SP 	



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<p>13. The RAE shall develop and maintain a customized and comprehensive website that includes:</p> <ul style="list-style-type: none"> • 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. <p>RAE Contract: Exhibit B-8—7.3.9</p>	<p>The following policy outlines CCHA’s website requirements.</p> <ul style="list-style-type: none"> • V.MI.13_CCHA Member and Provider Materials and Website Policy, pg. 5 <p>CCHA’s website contains all of the requisite information as follows.</p> <p>RAE’s contact information:</p> <ul style="list-style-type: none"> • https://www.cchacares.com/about-ccha/contact-us • https://www.cchacares.com/for-members/member-assistance <p>Member rights and handbooks:</p> <ul style="list-style-type: none"> • 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 <p>Grievance and appeal procedures and rights:</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/get-help • https://www.cchacares.com/for-members/appeals-and-grievances 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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	<ul style="list-style-type: none"> • https://www.cchacares.com/for-members/frequently-asked-questions • https://www.cchacares.com/for-members/member-benefits-services <p>General functions of the RAE:</p> <ul style="list-style-type: none"> • 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 <p>Trainings for providers:</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-providers/provider-resources-training <p>Training for members:</p> <ul style="list-style-type: none"> • Health Topics Library • https://www.cchacares.com/aslmedicaid 	



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	<p>Provider directory:</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/find-a-provider <p>Access to care standards:</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/frequently-asked-questions <p>Health First Colorado Nurse Advice Line:</p> <ul style="list-style-type: none"> • 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 <p>Colorado Crisis Services information:</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/contact-information-resources • https://www.cchacares.com/for-members/options • https://www.cchacares.com/behavioralhealth <p>A link to the Department's website for standardized information such as member rights and handbooks:</p>	



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	<ul style="list-style-type: none"> • 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 	
<p>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):</p> <ul style="list-style-type: none"> • 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. <p><i>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</i></p>	<p>CCHA’s Provider Directory is updated daily, and contains the following provider-attested information on contracted network providers:</p> <ul style="list-style-type: none"> • 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) • 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, 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<p><i>updated provider information.</i></p> <p align="right"><i>42 CFR 438.10(h)(1-3)</i></p> <p>RAE Contract: Exhibit B-8—7.3.9.1.6-8</p>	<p>they can call CCHA Member Support Services and a paper version will be provided free of charge upon request.</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/find-a-provider 	
<p>15. Provider directories are made available on the RAE’s website in a machine-readable file and format.</p> <p align="right"><i>42 CFR 438.10(h)(4)</i></p> <p>RAE Contract: Exhibit B-8—7.3.9.1.9</p>	<p>The CCHA Provider Directory can be exported into CSV, Excel, and PDF formats, with the option to copy or print.</p> <ul style="list-style-type: none"> • https://www.cchacares.com/for-members/find-a-provider 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following:</p> <ul style="list-style-type: none"> • 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 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. 	<p>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.</p> <ul style="list-style-type: none"> • 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 <p>The following insert provides information for members regarding CCHA’s care coordination services and is available in English and Spanish.</p> <ul style="list-style-type: none"> • V.MI.16_CCHA Care Coordination Insert_ENG, entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<ul style="list-style-type: none"> 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. <p>RAE Contract: Exhibit B-8—7.3.6.1</p>	<ul style="list-style-type: none"> V.MI.16_CCHA Care Coordination Insert_SP, entire document https://www.cchacares.com/for-members/connect-with-a-care-coordinator <p>The following insert provides information for members regarding Health First Colorado dental benefits and is available in English and Spanish.</p> <ul style="list-style-type: none"> V.MI.16_CCHA Dental Insert, entire document https://www.cchacares.com/dental <p>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.</p> <ul style="list-style-type: none"> V.MI.16_CCHA ER Handout_ENG, entire document V.MI.16_CCHA ER Handout_SP, entire document CCHA Contact Information & Resources (cchacares.com) https://www.cchacares.com/for-members/options 	



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	<p>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.</p> <ul style="list-style-type: none"> • V.MI.16_CCHA Transportation Insert, entire document • https://www.cchacares.com/for-members/transportation <p>The following document for members serves as a quick reference guide to behavioral health services and is available in English and Spanish.</p> <ul style="list-style-type: none"> • 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 <p>CCHA’s single toll-free customer service phone number is listed on:</p> <ul style="list-style-type: none"> • 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 	



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	<ul style="list-style-type: none"> • 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 <p>CCHA’s email address can be found on:</p> <ul style="list-style-type: none"> • CCHA website Contact Us page <p>CCHA’s website address can be found on:</p> <ul style="list-style-type: none"> • 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 	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>CCHA includes State relay information on:</p> <ul style="list-style-type: none"> • CCHA website Contact Us page <p>All member facing print materials including:</p> <ul style="list-style-type: none"> • 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 <p>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:</p> <ul style="list-style-type: none"> • CCHA website Member Benefits & Services page: CCHAcares.com/benefits • CCHA website Connect with a Care Coordinator page: CCHAcares.com/carecoordinator • CCHA website Frequently Asked Questions page: CCHAcares.com/faq 	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Member facing print materials including:</p> <ul style="list-style-type: none"> • 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 <p>Which populations are subject to mandatory enrollment into the Accountable Care Collaborative is located on:</p> <ul style="list-style-type: none"> • CCHA website Frequently Asked Questions page: • CCHAcares.com/faq <p>The service area covered by CCHA is included on:</p> <ul style="list-style-type: none"> • 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 <p>Member facing print materials including:</p> <ul style="list-style-type: none"> • V.MI.16_CCHA Map to Medicaid_ENG, entire document 	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • 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 <p>Information on Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit can be found on:</p> <ul style="list-style-type: none"> • CCHA website Member Benefits & Services page • CCHA & Health First Colorado CCHA website Member Frequently Asked Questions page <p>Member facing print materials including:</p> <ul style="list-style-type: none"> • 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 <p>Any restrictions on the member's freedom of choice among network providers:</p> <ul style="list-style-type: none"> • Not applicable. CCHA does not restrict member's choice of provider. 	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> Refer to CCHA’s Member Rights and Protections Policy and the CCHA website Frequently Asked Questions page. <p>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:</p> <ul style="list-style-type: none"> CCHA website Member Frequently Asked Questions page <p>Information on CCHA’s responsibilities for coordination of member care can be found on:</p> <ul style="list-style-type: none"> 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 V.MI.16_CCHA Map to Medicaid_SP, entire document V.MI.16_CCHA Behavioral Health Reference Guide_ENG, entire document 	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> V.MI.16 CCHA Behavioral Health Reference Guide_SP, entire document <p>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.</p> <ul style="list-style-type: none"> CCHA Frequently Asked Questions (cchacares.com) 	
<p>17. The RAE provides member information by either:</p> <ul style="list-style-type: none"> Mailing a printed copy of the information to the member’s mailing address. Providing the information by email after obtaining the member’s agreement to receive the information by email. Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. 	<p>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.</p> <ul style="list-style-type: none"> V.MI.17_CCHA_Member and Provider Materials and Website Policy, pg. 2 <p>The following document outlines CCHA’s policy regarding communicating with members via email or text message.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> Providing the information by any other method that can reasonably be expected to result in the member receiving that information. <p align="right"><i>42 CFR 438.10(g)(3)</i></p> <p>RAE Contract: Exhibit B-8—None</p>	<ul style="list-style-type: none"> V.MI.17_CCHA_Patient Consent for E-Mail and SMS Text Messaging Policy, entire document <p>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.</p> <ul style="list-style-type: none"> V.MI.17_CCHA_Member Unsecured Email Consent Form_ENG, entire document V.MI.17_CCHA_Member Unsecured Email Consent Form_SP, entire document <p>The following document outlines CCHA’s policy related to emailing protected health information (PHI).</p> <ul style="list-style-type: none"> V.MI.17_CCHA_Emailing PHI by Workforce Members Policy, entire document <p>The following document outlines CCHA’s policy regarding the use of communication plans to establish boundaries, if deemed necessary, when communicating with members.</p> <ul style="list-style-type: none"> V.MI.17_CCHA_Member Communication Plan Policy, entire document 	



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Standard V—Member Information Requirements		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>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.</p> <ul style="list-style-type: none"> V.MI.17_CCHA_Member Communication Plan Template, entire document 	
<p>18. The RAE must make available to members, upon request, any physician incentive plans in place.</p> <p align="right"><i>42 CFR 438.10(f)(3)</i></p> <p>RAE Contract: Exhibit B-8—None</p>	<p>CCHA includes information about its physician incentive plans on the Frequently Asked Questions page of its website.</p> <ul style="list-style-type: none"> https://www.cchacares.com/for-members/frequently-asked-questions 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> 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%			



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Standard VII—Provider Selection and Program Integrity		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor implements written policies and procedures for selection and retention of providers.</p> <p align="right"><i>42 CFR 438.214(a)</i></p> <p>RAE Contract: Exhibit B-8—9.1.6</p>	<p>The following documents outline selection and retention policies and procedures for CCHA physical health providers.</p> <ul style="list-style-type: none"> 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 <p>CCHA’s selection and retention criteria is posted to the public website.</p> <ul style="list-style-type: none"> https://www.cchacares.com/providers/provider-network-qualifications/ <p>The following document describes how CCHA recruits and contracts with new providers and applicable circumstances for recruiting new providers to join its network.</p> <ul style="list-style-type: none"> 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 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following documents outline which provider types CCHA contracts with and ensures an adequate network to meet the needs of members.</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <ul style="list-style-type: none"> • VII.PSPI.01_CCHA Credentialing Policy, entire document <p>The following documents outline CCHA’s network management strategies that aid in provider retention in Region 7.</p> <ul style="list-style-type: none"> • VII.PSPI.01_Network Management Strategic Pln HCPF Response_FY23-24_R7, entire document • VII.PSPI.01_Network Management Strategic Pln HCPF Response_FY23-24_R7, entire document 	



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>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).</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.214(b)</i></p> <p>RAE Contract: Exhibit B-8—9.3.5.2.1 and 9.3.6</p>	<p>The following document outlines CCHA’s credentialing and recredentialing process for behavioral health providers, which follows NCQA standards.</p> <ul style="list-style-type: none"> VII.PSPI.02_CCHA Credentialing Policy, entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>3. The Contractor’s provider selection policies and procedures include provisions that the Contractor does not:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.12(a)(1) and (2) 42 CFR 438.214(c)</i></p> <p>RAE Contract: Exhibit B-8—9.1.6.1-2</p>	<p>The following documents outline the non-discrimination policies as they apply to physical health providers.</p> <ul style="list-style-type: none"> VII.PSPI.03_Request to Join Provider Network - PCMP Policy, p. 2 VII.PSPI.03_CCHA Physical Health Provider Manual Chapter 7 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.03_CCHA BH Provider Manual p. 79 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following document outlines the non-discrimination policy for CCHA’s Credentialing program.</p> <ul style="list-style-type: none"> VII.PSPI.03_CCHA Credentialing Policy, p. 4 	
<p>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:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.12(a-b)</i></p> <p>RAE Contract: Exhibit B-8—9.1.6.4, 9.1.9, and 14.4.11</p>	<p>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.</p> <ul style="list-style-type: none"> VII.PSPI.04_CCHA PCMP License Screening Process, p. 2 <p>The following document demonstrates how CCHA documents when a provider’s request to join the PCMP network is denied.</p> <ul style="list-style-type: none"> VII.PSPI.04_CCHA RTJ Denial Tracker, entire document <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.04_CCHA Denial for License Issues Template Letter, entire document VII.PSPI.04_Initial Denial Letter (Both R6 and R7) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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	<ul style="list-style-type: none"> VII.PSPI.04_Business Denial Letter (Both R6 and R7) VII.PSPI.04_Initial Denial Letter (Both R6 and R7) <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.04_CCHA Credentialing Policy, entire document 	
<p>5. The Contractor has a signed contract or participation agreement with each provider.</p> <p align="right"><i>42 CFR 438.206(b)(1)</i></p> <p>RAE Contract: Exhibit B-8—9.1.13</p>	<p>The following documents are the standard contract templates that CCHA uses to contract with physical health providers in its network.</p> <ul style="list-style-type: none"> VII.PSPI.05_CCHA PCMP Agreement Template, entire document VII.PSPI.05_CCHA ACN Agreement Template, entire document <p>The following document includes a statement that PCMPs must sign agreements.</p> <ul style="list-style-type: none"> VII.PSPI.05_CCHA Physical Health Provider Manual, Chapter 2 <p>The following documents outline how CCHA audits contracted physical health providers and notifies internal and external staff of changes.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • VII.PSPI.05_Kchecks User Guide, entire document • VII.PSPI.05_Contract Notifications Procedure, entire document <p>The following document is the template base contract CCHA uses to contract with providers.</p> <ul style="list-style-type: none"> • VII.PPPI.05_CO RAE BH Contract Template entire document <p>The following documents provide evidence that CCHA enters into signed contracts with each provider in the R7 network.</p> <ul style="list-style-type: none"> • VII.PSPI.05_Network Management Strategic Pln_FY23-24_R7, Section (1), entire document • VII.PSPI.05_Network Management Strategic Pln HCPF Response_FY23-24_R7, entire document 	



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<p>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.</p> <ul style="list-style-type: none"> The Contractor performs monthly monitoring against HHS OIG’s List of Excluded Individuals. <p><i>(This requirement also requires a policy.)</i></p> <p align="right">42 CFR 438.214(d) 42 CFR 438.610</p> <p>RAE Contract: Exhibit B-8—9.1.15 and 17.10.5</p>	<p>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.</p> <ul style="list-style-type: none"> VII.PSPI.06_Excluded Individuals and Entities Policy, p. 2 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.06_Request to Join Provider Network PCMP Policy, p. 2 <p>The following policy demonstrates providers who are excluded from participation are immediately denied.</p> <ul style="list-style-type: none"> VII.PSPI.06_PCMP License Screening Process, p. 1 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.06_CCHA Physical Health Provider Manual, Chapter 7 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>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.</p> <ul style="list-style-type: none"> • VII.PSPI.05_CCHA PCMP Agreement Template, p. 14 • VII.PSPI.05_CCHA ACN Agreement Template, p. 14 <p>The following document outlines the process by which providers are continuously monitored on the listed government agencies websites for exclusion of participation.</p> <ul style="list-style-type: none"> • VII.PSPI.06_Kchecks User Guide, p. 1 <p>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.</p> <ul style="list-style-type: none"> • VII.PSPI.06_KChecks Matches, entire document • VII.PSPI.06_KChecks Notes Report, entire document <p>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</p>	



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	<p>federal health care programs, as well as CCHA’s monthly monitoring of the LEIE.</p> <ul style="list-style-type: none"> VII.PSPI.06_Credentialing Policy, p. 10, 13, 30-31 <p>The following section of the policy confirms CCHA’s requirement to not contract with excluded providers during the provider recruitment process.</p> <ul style="list-style-type: none"> VII.PSPI.06_CCHA Annual BH Recruitment Strategy, p. 1-2 	
<p>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.</p> <p align="right"><i>42 CFR 438.610</i></p> <p>RAE Contract: Exhibit B-8—17.9.4.2.3</p>	<p>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.</p> <ul style="list-style-type: none"> VII.PSPI.07_Excluded Individuals and Entities Policy, p. 2 and 4 <p>The following documents are the Region 7 submission.</p> <ul style="list-style-type: none"> VII.PSPI.07_CCHA Ownership and Control Disclosure FY23-24_R7, entire document VII.PSPI.07_CCHA Ownership and Control Disclosure FY23-24 Attachment_R7, entire document 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>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:</p> <ul style="list-style-type: none"> • 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. <p align="right"><i>42 CFR 438.102(a)(1)</i></p> <p>RAE Contract: Exhibit B-8—14.7.3</p>	<p>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.</p> <ul style="list-style-type: none"> • VII.PSPI.08_CCHA BH Provider Manual p. 79 <p>The following document includes a similar statement for physical health providers.</p> <ul style="list-style-type: none"> • VII.PSPI.08_CCHA Physical Health Provider Manual, p. 33 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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<p>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:</p> <ul style="list-style-type: none"> To the State upon contracting or when adopting the policy during the term of the contract. To members before and during enrollment. To members 30 days prior to adopting the policy with respect to any particular service. <p align="right"><i>42 CFR 438.102(a)(2)-(b)</i></p> <p>RAE Contract: Exhibit B-8—7.3.6.1.13-14 and 14.4.8</p>	<p>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:</p> <ul style="list-style-type: none"> 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes:</p> <ul style="list-style-type: none"> 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. 	<p>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.</p> <ul style="list-style-type: none"> VII.PSPI.10_CCHA Compliance Plan_FY23-24_R6, entire document VII.PSPI.10_CCHA Compliance Plan_FY23-24_R7, entire document. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<ul style="list-style-type: none"> 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 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. <p align="right"><i>42 CFR 438.608(a)(1)</i></p> <p>RAE Contract: Exhibit B-8—17.1.3 and 17.1.5.1-7</p>	<p>Compliance plan mirrors the R6 plan. The R6 plan is annotated</p> <p>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 comply with all applicable laws and policies and procedures.</p> <ul style="list-style-type: none"> VII.PSPI.10_Elevance Code of Conduct, entire document VII.PSPI.10_PHP Code of Conduct, entire document <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.10_Compliance Investigations Policy, page 2 VII.PSPI.10_Elevance Code of Conduct, page 9 <p>The following document outlines how Compliance performs routine monitoring and enacts audit plans.</p>	



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Standard VII—Provider Selection and Program Integrity		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • VII.PSPI.10_Compliance Monitoring and Auditing Policy, entire document <p>The following documents all support CCHA’s Compliance Plan and our adherence.</p> <ul style="list-style-type: none"> • VII.PSPI.10_Reporting of Fraud Abuse Investigations Policy, entire document • VII.PSPI.10_CCHA Provider Payment Suspension Policy, entire document • 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 	



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Standard VII—Provider Selection and Program Integrity		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> 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 	
<p>11. The Contractor’s administrative and management procedures to detect and prevent fraud, waste, and abuse include:</p> <ul style="list-style-type: none"> 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). <p align="right"><i>42 CFR 438.608(a)(6-8)</i></p> <p>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</p>	<p>The following documents apply to PHP employees who work for or on behalf of CCHA.</p> <ul style="list-style-type: none"> 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 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.1_CCHA Physical Health Provider Manual, p. Chapter 6 <p>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.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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	<ul style="list-style-type: none"> VII.PSPI.11_Provider Payment Suspension - CO (Both Regions 6 and 7), entire document VII.PSPI.11_PH Provider Payment Suspension Policy <p>The following documents outline the operations and processes of the Elevance Special Investigations Unit, which includes developing and maintaining relationships with the State Medicaid Fraud Control Unit.</p> <ul style="list-style-type: none"> 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 <p>The following policy provides guidance for the False Claims Act to Elevance employees, including whistleblower protections and non-retaliation policy.</p> <ul style="list-style-type: none"> VII.PSPI.11_Fraud Waste and Abuse Detection and Prevention in Health Plan Operations Policy, entire document <p>The following section of the Program Integrity Plan outlines how Compliance and Program Integrity work together to enforce associate</p>	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>compliance with state and federal laws, including the Deficit Reduction Act of 2005.</p> <ul style="list-style-type: none"> VII.PSPI.11_Program Integrity Plan, p. 27 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.11_Provider Payment Suspension - CO (Both Regions 6 and 7) <p>The following policy outlines the requirements for reporting suspected fraud, waste, and abuse to the appropriate State agencies by Elevance’s SIU.</p> <ul style="list-style-type: none"> VII.PSPI.11_Reporting of Fraud and Abuse Investigations(Regions 6&7)_Entire document <p>The following is the form CCHA uses to notify HCPF and the MFCU of suspected provider fraud.</p> <ul style="list-style-type: none"> VII.PSPI.11_MCO Suspected Provider Fraud Written Notice Form eff20221114(Regions 6&7)_Entire document 	



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<p>12. The Contractor’s Compliance Program includes:</p> <ul style="list-style-type: none"> • 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. • 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. <p align="right"><i>42 CFR 438.608 (a)(2-5)</i></p> <p>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</p>	<p>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.</p> <ul style="list-style-type: none"> • VII.PSPI.12_CCHA Notice of a Provider Termination or Practice Closure Policy <p>The following document outlines the procedure to notify the State when a network provider is terminated from the CCHA physical health network.</p> <ul style="list-style-type: none"> • VII.PSPI.12_PCMP Network Disaffiliation Procedure, entire document <p>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.</p> <ul style="list-style-type: none"> • 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 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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	<p>The following policy outlines how CCHA verifies members did receive services billed by their providers through claims sampling.</p> <ul style="list-style-type: none"> VII.PSPI.12_Member Verification of Services Policy, entire document <p>The following policy describes the process for terminating a CCHA network behavioral health provider for cause, including notification to HCPF.</p> <ul style="list-style-type: none"> VII.PSPI.12_CCHA Provider Termination with Cause Policy, entire document <p>The following section of the policy outlines the requirements under the False Claims Act to return overpayments due to fraud to the State within 60 calendar days.</p> <ul style="list-style-type: none"> VII.PSPI.12_Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations (Both Regions 6 and 7) p. 13 <p>The following section of the Program Integrity Plan outlines the requirement of Program Integrity and SIU to report all overpayments to the appropriate agencies.</p> <ul style="list-style-type: none"> VII.PSPI.12_Program Integrity Plan-ASKUBAL3-CCHA, p. 30 	



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	<p>The following policy outlines the process for reviewing and processing overpayments, including those related to suspected fraud.</p> <ul style="list-style-type: none"> VII.PSPI.12_Overpayments Policy (Both Regions 6&7), entire document <p>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.</p> <ul style="list-style-type: none"> 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 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.12_R6 Monthly FWA Report 06-23, entire document VII.PSPI.12_R7 Monthly FWA Report 06-23, entire document 	



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<p>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.</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.608(b)</i></p> <p>RAE Contract: Exhibit B-8—9.2.1.1, 9.3.2, and 17.9.2</p>	<p>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:</p> <ul style="list-style-type: none"> VII.PPPI.13_CCHA Excluded Individuals and Entities Policy, entire document <p>The following document outlines the BH Provider recruitment Strategy:</p> <ul style="list-style-type: none"> VII.PSPI.13_CCHA Annual BH Recruitment Strategy 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>14. The Contractor has procedures to provide to the State:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.608(c)</i></p>	<p>The following policy outlines our requirement to notify appropriate state agencies of any excluded individuals.</p> <ul style="list-style-type: none"> VII.PSPI.14_CCHA Excluded Individuals and Entities Policy, p. 3 <p>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.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>RAE Contract: Exhibit B-8—17.3.1.5.1.1, 17.9.4.3, and 17.10.2.1</p>	<ul style="list-style-type: none"> VII.PSPI.14_State Notification Disclosure of Change In Ownership or Controlling Interest Policy, entire document <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.14_CCHA Ownership and Control Disclosure FY23-24 R7, entire document VII.PSPI.14_CCHA Ownership and Control Disclosure FY23-24 Attachment R7, entire document <p>The following policy outlines the process to identify and adjust excess capitation payments or other payments from the State.</p> <ul style="list-style-type: none"> VII.PSPI.14_Premium Discrepancy Report Resolution Process (Region 6 and 7), entire document 	
<p>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.</p> <ul style="list-style-type: none"> The Contractor reports semi-annually to the State on recoveries of overpayments. 	<p>The following document outlines the requirements for CCHA providers regarding overpayments.</p> <ul style="list-style-type: none"> VII.PSPI.15_CO RAE BH Contract Template, p. 4 <p>The following section of the BH provider manual informs providers on the overpayment recovery process, including where to find applicable forms,</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<p align="center"><i>42 CFR 438.608 (d)(2) and (3)</i></p> <p>RAE Contract: Exhibit B-8—17.1.5.8 and 17.3.1.2.4.4</p>	<p>contact information, as well as applicable laws and regulations regarding overpayments.</p> <ul style="list-style-type: none"> VII.PSPI.15_CCHA BH Provider Manual - Claims Overpayment Recovery Procedure, p. 42 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.15_Provider Overpayment Request Letter First Notice, entire document <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.15_Provider Overpayment Request Letter Final Notice, entire document <p>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</p>	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>reports, as well as member service verification notices sent during the reporting period.</p> <ul style="list-style-type: none"> VII.PSPI.15_R7_FWARpt_Q3Q4FY22-23, entire document 	
<p>16. The Contractor provides that members are not held liable for:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>42 CFR 438.106</i></p> <p>RAE Contract: Exhibit B-8—14.14.1-2 and 17.13.2-4</p>	<p>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.</p> <ul style="list-style-type: none"> VII.PSPI.16_Physical Health Provider Manual, p. 12 <p>The following newsletter articles are an example of the reminders send out to providers about members’ liabilities:</p> <ul style="list-style-type: none"> VII.PSPI.16_CCHA Provider Newsletter_July 2023, P. 3 VII.PSPI.16_CCHA Provider Newsletter_August 2023, P. 3 <p>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.</p> <ul style="list-style-type: none"> VII.PSPI.16_CCHA Behavioral Health Provider Manual - Billing Members, page 40 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following section of the provider contract holds CCHA members harmless from providers seeking payment from members for Medicaid covered services.</p> <ul style="list-style-type: none"> 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%			



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>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.</p> <p align="right"><i>42 CFR 438.230(b)(1)</i></p> <p>RAE Contract: Exhibit B-8—4.2.13</p>	<p>The following document serves as the model state-specific exhibit where Elevance enters into a subcontractor agreement for work performed for CCHA.</p> <ul style="list-style-type: none"> IX.SRD.01_Colorado Subcontractor Exhibit _01.24.19 <p>The following document is the overarching contract Elevance maintains with CyraCom to perform services on behalf of CCHA. CyraCom provides Language Interpretation Services.</p> <ul style="list-style-type: none"> 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 <p>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.</p> <ul style="list-style-type: none"> IX.SRD.01_CyraCom Contract Summary, entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following contract outlines the delegated credentialing agreement CCHA maintains with CU Medicine.</p> <ul style="list-style-type: none"> IX.SRD.01_CCHA_CU Medicine Agreement <p>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.</p> <p>The following document outlines CCHA's policy and procedure for monitoring ACN performance, and mechanisms for oversight of contracted duties.</p> <ul style="list-style-type: none"> IX.SRD.01_CCHA ACN Monitoring and Oversight Policy entire document <p>The following document outlines CCHA's policy for assessing potential ACN candidates to determine ability to fulfill contracted care coordination activities.</p> <ul style="list-style-type: none"> IX.SRD.01_CCHA ACN Assessment Policy entire document 	



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following document outlines CCHA's incentive program for ACNs and establishes performance goals and mechanisms to monitor.</p> <ul style="list-style-type: none"> IX.SRD.01_ACN Provider Incentive Program entire document <p>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.</p> <ul style="list-style-type: none"> IX.SRD.01_ACN Care Coordination Reporting Specs entire document <p>The following document is completed by ACNs and submitted to CCHA as part of the quarterly case audit process.</p> <ul style="list-style-type: none"> IX.SRD.01_ACN Case Audit Template entire document <p>The following document is the action plan template used with ACNs after audits are conducted.</p> <ul style="list-style-type: none"> IX.SRD.01_ACN Action Planning Template entire document <p>The following document provides the ACN with detailed information on earned key performance indicator (KPI) and/or value-based payment Performance Pool incentive dollars.</p>	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> IX.SRD.01_ACN KPI VBP Incentive Summary, entire document <p>The following document is the operational policy providing an overview of how members are referred to CCHA for care coordination.</p> <ul style="list-style-type: none"> IX.SRD.01_Referral Procedures and Timeline Expectations Policy, entire document <p>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:</p> <ul style="list-style-type: none"> 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 IX.SRD.01_PHE Continuous Enrollment Unwind PCMP Guidance, entire document <p>The following documents are used by rural contractors, providers and community partners to refer members in Region 7 to CCHA for care coordination.</p>	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> IX.SRD.01_CCHA Referral Form_R7 IX.SRD.01_CCHA Referral Form_R7 Teller County <p>The following documents are sample training desktop guides provided to the rural contractors to support Essette operations.</p> <ul style="list-style-type: none"> IX.SRD.01_RC Guide 1_Getting Started In Essette PM, entire document IX.SRD.01_RC Guide 3_PM Essette_Enrolling a Member in a Campaign, entire document IX.SRD.01_RC Guide 6_ PM Essette_Member Benefits Assessment entire document <p>The following documents are sample meeting minutes from monthly rural oversight and monitoring meetings with the rural contractors.</p> <ul style="list-style-type: none"> IX.SRD.01_Rural Contractor Meetings Documentation_AMC-Teller entire document IX.SRD.01_Rural Contractor Meeting Notes_Aspen Mine Center entire document IX.SRD.01_Rural Contractor Meeting Notes_Rocky Mountain Rural Health, entire document 	



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>2. All contracts or written arrangements between the Contractor and any subcontractor specify:</p> <ul style="list-style-type: none"> 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. <p><i>Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly owned subsidiaries of the RAE are not considered subcontractors.</i></p> <ul style="list-style-type: none"> <p align="right"><i>42 CFR 438.230(b)(2) and (c)(1)</i></p> <p>RAE Contract: Exhibit B-8—4.2.13.6</p>	<p>The following document is the contract template used for our Accountable Care Network providers.</p> <ul style="list-style-type: none"> IX.SRD.02_ACN Agreement Template_2023, entire document IX.SRD.02_Colorado Subcontractor Exhibit _01.24.19 <ul style="list-style-type: none"> 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 <p>The following documents are the contracts used for our rural contractors.</p> <ul style="list-style-type: none"> IX.SRD.02_CCHA Rural Contract Service Agreement_RMRH, entire document IX.SRD.02_CCHA Rural Contract Service Agreement_AMC entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>3. The Contractor’s written agreement with any subcontractor includes:</p> <ul style="list-style-type: none"> The subcontractor’s agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. <p align="right"><i>42 CFR 438.230(c)(2)</i></p> <p>RAE Contract: Exhibit B-8—4.2.13.6</p>	<p>The following templates outline the subcontractor’s responsibilities to follow all applicable state and federal laws and regulations.</p> <ul style="list-style-type: none"> IX.SRD.03_ACN Agreement Template_2023, pg. 9 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 <p>The following rural contractor contracts outline the subcontractors’ responsibilities to follow all applicable state and federal laws and regulations.</p> <ul style="list-style-type: none"> IX.SRD.2_CCHA Rural Contract Service Agreement_RMRH, pg. 10 IX.SRD.2_CCHA Rural Contract Service Agreement_AMC, pg. 10 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>4. The written agreement with the subcontractor includes:</p> <ul style="list-style-type: none"> • 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. <p align="right"><i>42 CFR 438.230(c)(3)</i></p> <p>RAE Contract: Exhibit B-8—4.2.13.6</p>	<p>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.</p> <ul style="list-style-type: none"> • IX.SRD.2_ACN Agreement Template_2023, pgs. 7-8 • IX.SRD.04_Colorado Subcontractor Exhibit _01.24.19 <ul style="list-style-type: none"> ○ Section 5, Page 2. ○ Section 5.ii., Page 2. ○ Section 6, Page 2. • 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 <p>The following documents outline the subcontractors’ requirements to abide by the right for government entities to inspect and audit elements that pertain to the activities performed for CCHA’s contract.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> IX.SRD.2_CCHA Rural Contract Service Agreement_RMRH, pg. 10 IX.SRD.2_CCHA Rural Contract Service Agreement_AMC, pg. 10 	
<p>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.</p>		
<p>Required Actions: CCHA must ensure, via revisions or amendments, that all subcontractor agreements include the following required language:</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> – 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. 		



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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%



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Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.</p> <p align="right"><i>42 CFR 438.330(a)(1)</i></p> <p>RAE Contract: Exhibit B-8—16.1.1</p>	<p>The following document outlines the Peer Review process for evaluating quality incidents as part of CCHA’s QAPI program.</p> <ul style="list-style-type: none"> • X.QAPI.01_QOC Peer Review Process, entire document <p>The following policy outlines CCHA’s grievance process for member complaints and complaints made on behalf of members.</p> <ul style="list-style-type: none"> • X.QAPI.01_Member Grievances Policy, entire document <p>The following policy outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines.</p> <ul style="list-style-type: none"> • X.QAPI.01_CCHA Quality of Care Policy entire document <p>The following policy describes the Critical Incidents reporting process CCHA manages under its QAPI program.</p> <ul style="list-style-type: none"> • X.QAPI.01_Critical Incident Reporting Policy - CO entire document <p>The following sections of the BH and PH provider manuals outline CCHA’s QAPI program for CCHA network providers.</p> <ul style="list-style-type: none"> • X.QAPI.01_CCHA BH Provider Manual, pages 85-86 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following document is used to assess quality and performance for behavioral health incentive program measures for behavioral health providers.</p> <ul style="list-style-type: none"> • X.QAPI.01_Behavioral Health Scorecards <p>The following documents outline the incentive program for physical health providers, aimed at improving the quality of care given to Medicaid members.</p> <ul style="list-style-type: none"> • X.QAPI.01_CCHA PCMP Incentive Program, entire document • X.QAPI.01_CCHA ACN Incentive Program, entire document <p>The following documents describe CCHA’s Quality Plan</p> <ul style="list-style-type: none"> • X. QAPI.01_CCHA Quality Improvement Plan_SF23-24_R7, entire document • X.QAPI.01_CCHA Quality Report_FY22-23_R7, entire document 	
<p>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:</p> <ul style="list-style-type: none"> • Measurement of performance using objective quality indicators. 	<p>The following documents are for the BH and PH PIPs and include closeout and module submissions.</p> <ul style="list-style-type: none"> • X.QAPI.02_PIP Submission Form FUH R7 entire doc • X.QAPI.02_PIP Intervention Worksheet FUH R7, entire doc • X.QAPI.02_PIP Submission Form SDOH R7, entire doc • X.QAPI.02_PIP Intervention Worksheet SDOH_R7, entire doc • X.QAPI.02_PIP Validation Report R7 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> 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. <p><i>For RAEs two PIPs are required, one administrative and one clinical.</i></p> <p align="center"><i>42 CFR 438.330(b)(1) and (d)(2) and (3)</i></p> <p>RAE Contract: Exhibit B-8—16.2.1.1, 16.3.5, and 16.3.8</p>	<ul style="list-style-type: none"> X.QAPI.02_R7_New Clinical PIP Topic Selection Form X.QAPI.02_R7_SDOH_CO2023-24 PIP Submission Form_F1 X.QAPI.02_SDOH_R7_CO2023-24_Intervention Worksheet_F1 X.QAPI.02_R7_CO2023-24 PIP Submission Form_F1 X.QAPI.02_R7_CO2023-24_Intervention Worksheet_F1 	
<p>3. The Contractor’s QAPI Program includes collecting and submitting (to the State):</p> <ul style="list-style-type: none"> 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. <p align="center"><i>42 CFR 438.330(b)(2) and (c)</i></p> <p>RAE Contract: Exhibit B-8—16.4.1 and 16.4.4</p>	<p>The following policy outlines how performance data is collected and submitted to HCPF.</p> <ul style="list-style-type: none"> X.QAPI.03_Performance Measurement Policy and Procedure <p>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.</p> <ul style="list-style-type: none"> X.QAPI.03_CCHA KPI Dashboards <p>The following policy outlines how performance data is collected and submitted to HCPF.</p> <ul style="list-style-type: none"> X.QAPI0.3_ECC Attestation Form_R7, entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> X.QAPI.03_SFY 2022-2023 ECC Workbook_R7, entire document <p>The following documents describe CCHA’s Quality Plan.</p> <ul style="list-style-type: none"> X. QAPI.03_CCHA Quality Improvement Plan_SFY23-24_R7, entire document 	
<p>4. The Contractor’s QAPI Program includes mechanisms to detect both underutilization and overutilization of services.</p> <p align="right"><i>42 CFR 438.330(b)(3)</i></p> <p>RAE Contract: Exhibit B-8—16.6.1</p>	<p>The following policy outlines the Client Over Utilization Program.</p> <ul style="list-style-type: none"> X.QAPI.04_CC_COUP Policy, entire document <p>The following documents demonstrate how CCHA members are reviewed for utilizing high rates of 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.</p> <ul style="list-style-type: none"> X.QAPI.04_CCHA Top 100 Report X.QAPI.04_CCHA BH Facility Report <p>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.</p> <ul style="list-style-type: none"> X.QAPI.04_Member Lookup Report Screenshots, entire document X.QAPI.04_SEP CCB Complex Case Review Referral Form, entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>The following document is an example of a Power BI dashboard used to detect underutilization.</p> <ul style="list-style-type: none"> X.QAPI.04_CCHA KPI Dashboards entire document <p>The following document shows CCHA’s plan to outreach members who are non -utilizers of the system:</p> <ul style="list-style-type: none"> X.QAPI.04_EPSDT Outreach Plan R7, Page 4 	
<p>5. The Contractor’s QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.</p> <p><i>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.</i></p> <p align="right">42 CFR 438.330(b)(4)</p> <p>RAE Contract: Exhibit B-8—16.2.1.4 and 16.5.5 10 CCR 2505-10, Section 8.205.8</p>	<p>The following policy outlines how CCHA identifies and investigates quality of care concerns, as well as ongoing monitoring and state reporting guidelines.</p> <ul style="list-style-type: none"> X.QAPI.05_Quality of Care Policy, entire document <p>The following document is a template used for Complex Case Review meetings with the SEPs and CCBs in both regions.</p> <ul style="list-style-type: none"> X.QAPI.05 Complex Case Review Referral Form, entire document <p>The following document provides an overview of CCHA’s care coordination model, which includes special populations.</p> <ul style="list-style-type: none"> X.QAPI.05_CCHA Care Coordination Model, entire document <p>In order for Medicaid members or other stakeholders to be able to submit quality of care concerns at any point of</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>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.</p> <ul style="list-style-type: none"> • X.QAPI.05_CCHA Attestation for Grievance and QOC Training_MSS and CC, entire document • X.QAPI.05_CCHA R6 & R7_QOC-Grievance-Appeals Training 1.24.2023 <p>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).</p> <ul style="list-style-type: none"> • X.QAPI.05_CCHA Ascent DOC Partnership MOU, entire document <p>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</p> <ul style="list-style-type: none"> • 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 <p>CCHA has executed agreements with the Single Entry Points (SEPs) and Community Centered Boards (CCBs),</p>	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>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.</p> <ul style="list-style-type: none"> • X.QAPI.05_CCHA MOU_TRE • X.QAPI.05_TRE Workflow • X.QAPI.05_TRE Performance Pool Letter <p>The following documents are meeting minutes summarizing meetings between CCHA and BH facilities to discuss quality of care complaints filed against the facility.</p> <ul style="list-style-type: none"> • X.QAPI.05_R7 CCHA QMC Meeting Minutes 2_23_2023. • X.QAPI.05_R7 CCHA QMC Meeting Minutes 5_25_2023. • X.QAPI.05_R7 CCHA QMC Meeting Minutes 8_31_2023 	
<p>6. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum:</p> <ul style="list-style-type: none"> • Member surveys • Anecdotal information • Grievance and appeals data • Call center data 	<p>The following document outlines CAHPS results and the interventions made with appropriate providers as a result.</p> <ul style="list-style-type: none"> • X.QAPI.06_CCHA CAHPS Survey Findings and Interventions 2023 <p>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.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> Consumer Assessment of Healthcare Providers and Systems (CAHPS®)^{A-1} survey <p>RAE Contract: Exhibit B-8—16.5.1-3 and 16.5.6</p>	<ul style="list-style-type: none"> X.QAPI.06_CO Behavioral Health Member Appeals Core Process Policy 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-FY 22-23 X.QAPI.06_R7_GrieveAppealRpt_Q3-FY 22-23 X.QAPI.06_R6_GrieveAppealRpt_Q4-FY 22-23 	

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



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • X.QAPI.06_R7_GrieveAppealRpt_Q4-FY 22-23 <p>The following policy outlines CCHA’s grievance process for member complaints and complaints made on behalf of members, including complaints related to access issues.</p> <ul style="list-style-type: none"> • X.QAPI.1_Member Grievances Policy, entire document <p>The following document outlines call center quality metrics.</p> <ul style="list-style-type: none"> • X.QAPI.06_CCHA Call Line Statistics Report_0623_R6 • X.QAPI.06_CCHA Call Line Statistics Report_0623_R7 <p>CCHA’s Member Advisory Committee (MAC) engages Medicaid members to provide feedback on its program. The following documents provide information used to recruit members.</p> <ul style="list-style-type: none"> • X.QAPI.06_CCHA MAC Interest <p>The following document outlines the formal training process for CCHA Member Supports and Services and Care Coordination</p> <ul style="list-style-type: none"> • X.QAPI.06_CCHA Attestation for Grievance and QOC Training_MSS and CC • X.QAPI.06_QOC-GA Staff Training Attestation 	



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Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> X.QAPI.06_CCHA R6 & R7_QOC-Grievance-Appeals Training 1.24.2023 	
<p>7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis.</p> <p align="right"><i>42 CFR 438.330(e)(2)</i></p> <p>RAE Contract: Exhibit B-8—16.2.5</p>	<p>The following documents outline CCHA’s process for evaluating its Quality program.</p> <ul style="list-style-type: none"> X.QAPI.07_CCHA Quality Report_FY22-23_R6 X.QAPI.07_CCHA Quality Report_FY22-23_R7 <p>The following document demonstrates that CCHA evaluates the impact and effectiveness of its program regarding its KPI performance:</p> <ul style="list-style-type: none"> X.QAPI.07 KPI Workgroup Notes 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>8. The Contractor adopts practice guidelines that meet the following requirements:</p> <ul style="list-style-type: none"> 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. Are adopted in consultation with contracted health care professionals. Are reviewed and updated periodically as appropriate. <p align="right"><i>42 CFR 438.236(b)</i></p> <p>RAE Contract: Exhibit B-8—14.8.9.1-3</p>	<p>The following document outlines CCHA’s Clinical Practice Guidelines for BH conditions.</p> <ul style="list-style-type: none"> X.QAPI.08_CCHA BH Provider Manual, page 82 X.QAPI.08_Clinical Practice Guidelines <p>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.</p> <ul style="list-style-type: none"> X.QAPI.08_Clinical Criteria for Utilization Management Decisions-CO 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>9. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.</p> <p align="right"><i>42 CFR 438.236(c)</i></p> <p>RAE Contract: Exhibit B-8—14.8.9</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <p align="right"><i>42 CFR 438.236(d)</i></p> <p>RAE Contract: Exhibit B-8—14.8.10</p>	<p>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.</p> <ul style="list-style-type: none"> • X.QAPI.10_Clinical Practice Guidelines • 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data.</p> <p align="right"><i>42 CFR 438.242(a)</i></p> <p>RAE Contract: Exhibit B-8—15.1.1</p>	<p>The following document is an overview of the Management Information System Elevance utilizes on CCHA’s behalf for behavioral health services.</p> <ul style="list-style-type: none"> • X.QAPI.11_CO Elevance_GBD_MIS_v2.5, page 1 • X.QAPI.11_CCHA Data Flow, entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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).</p> <p align="right"><i>42 CFR 438.242(a)</i></p> <p>RAE Contract: Exhibit B-8—8.1, 15.1.1, and 15.1.1.3.2.1</p>	<p>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.</p> <ul style="list-style-type: none"> • X.QAPI.12_CO Elevance_GBD_MIS_v2.5, p. 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>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.</p> <ul style="list-style-type: none"> • 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. 	<p>The following diagram demonstrates how encounters are managed within Elevance’s system and relayed to the State.</p> <ul style="list-style-type: none"> • X.QAPI.13_CO Elevance_GBD_MIS_v2.5, p. 3 <p>The following policy outlines the process used to submit CCHA BH encounters to the State.</p> <ul style="list-style-type: none"> • X.QAPI.13_Colorado Encounters Process entire document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



**Appendix A. Colorado Department of Health Care Policy & Financing
 FY 2023–2024 Compliance Monitoring Tool
 for Colorado Community Health Alliance RAE 7**

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	Evidence as Submitted by the Health Plan	Score
<p align="right"><i>42 CFR 438.242(b)(1)</i></p> <p>RAE Contract: Exhibit B-8—15.2.2.3.1-2</p>		
<p>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).</p> <p align="right"><i>42 CFR 438.242(b)(2)</i></p> <p>RAE Contract: Exhibit B-8—15.2.2</p>	<p>The following section outlines which member and provider behavioral health data is maintained on behalf of CCHA.</p> <ul style="list-style-type: none"> • X.QAPI.14_CO Elevance_GBD_MIS_v2.5 p. 1-2 <p>The following policy outlines the process for reviewing, validating, and submitting encounters to the State.</p> <ul style="list-style-type: none"> • X.QAPI.14_Colorado Encounters Process <p>The following templates are examples of how CCHA collects member data.</p> <ul style="list-style-type: none"> • X.QAPI.14_Intake Assessment, entire document • X.QAPI.14_Adult HNA, entire document <p>The following templates collect physical health provider data, both initially when requesting to join the network, and as part of the ongoing review process.</p> <ul style="list-style-type: none"> • 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



**Appendix A. Colorado Department of Health Care Policy & Financing
FY 2023–2024 Compliance Monitoring Tool
for Colorado Community Health Alliance RAE 7**

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>15. The Contractor ensures that data received from providers are accurate and complete by:</p> <ul style="list-style-type: none"> • 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. <p align="right"><i>42 CFR 438.242(b)(3) and (4)</i></p> <p>RAE Contract: Exhibit B-8—15.2.2.3.1 and 15.2.2.3.6.1</p>	<p>The following policy outlines the process used to process claims and validate encounters.</p> <ul style="list-style-type: none"> • X.QAPI.15_Colorado Encounters Process • X.QAPI.15_CO Elevance_GBD_MIS_v2.5 <p>The following documents outline the data collected and the processes by which it is verified for physical health providers.</p> <ul style="list-style-type: none"> • 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 • 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 <p>The following document outlines CCHA’s data validation process.</p> <ul style="list-style-type: none"> • X.QAPI.15_CCHA Data Flow entire document <p>The following document outlines the data reporting specifications for member level reports reported to CCHA by the ACN.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



**Appendix A. Colorado Department of Health Care Policy & Financing
 FY 2023–2024 Compliance Monitoring Tool
 for Colorado Community Health Alliance RAE 7**

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> X.QAPI.15_ACN CC Reporting Specs, entire document <p>The following document outlines CCHA’s policy and procedure for collecting and submitting performance data to the State.</p> <ul style="list-style-type: none"> X.QAPI.15_Performance Measurement Policy and Procedure 	
<p>16. The Contractor:</p> <ul style="list-style-type: none"> 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). <p align="right"><i>42 CFR 438.242(c)</i></p> <p>RAE Contract: Exhibit B-8—15.2.2.1-2, 15.2.2.3.2, and 15.2.2.3.4</p>	<p>The following document describes the requirements for CCHA’s BH encounter system, including format and submission timeline after claim adjudication.</p> <ul style="list-style-type: none"> X.QAPI.16_CCHA_Encounter Data Mgmt System, p. 3 <p>The following policy outlines the process used to submit CCHA BH encounters to the State.</p> <ul style="list-style-type: none"> X.QAPI.16_Colorado Encounters Process 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



Appendix A. Colorado Department of Health Care Policy & Financing
FY 2023–2024 Compliance Monitoring Tool
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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
Cynthia Moreno	Project Manager III
Crystal Brown	Project Manager I
Holly Cherry (Observer)	Project Coordinator III
CCHA Participants	Title
Robert Avila	Manager II, Credentialing, Elevance Health
Lisa Banks-Flinn	Manager II, Grievance and Appeals, Elevance Health
Michelle Blady	Manager, Behavioral Health Services, Physician Health Partners
Janet Bonham	Manager I, Investigations, Elevance Health
Teresa Butterfield	Regulatory Compliance Consultant, Elevance Health
Clara Cabanis	Senior Manager, Strategy and Performance Management, Physician Health Partners
Leslie Carpenter	Manager, Premium Reconciliation, Elevance Health
Leigh Ann Cole	Manager, Clinical Quality, Elevance Health
Colleen Daywalt	Director, Corporate and Public Affairs, Physician Health Partners
Josie Dostie	Senior Network Manager, Physician Health Partners
Patrick Fox	President, Medicaid Health Plan, Elevance Health
Kelli Gill	Director, Behavioral Health Services, Elevance Health
Lisa Niguidula	Manager II, Grievance and Appeals, Elevance Health
Cara Hebert	Director, Account Management and External Partnerships, Physician Health Partners
Cathy Herrera	Grievance and Appeals Audit Specialist, Elevance Health
Laketa Hicks	Data Integrity Specialist, Physician Health Partners
Diana Highsmith	Business Information Consultant, Elevance Health
George Hughes	Director Data Analysis and Planning, Elevance Health
Camila Joao	Clinical Quality Program Manager, Elevance Health
Natalie Johnson	Behavioral Health Care Manager, Elevance Health
Thomas Johnson	Director, Application Development and Data Management, Physician Health Partners

CCHA Participants	Title
JP Joyce	Director Compliance I, Elevance Health
Andrea Kedley	Supervisor, Community Partnerships, Physician Health Partners
Erica Kloehn	Regional Vice President, Provider Solutions, Elevance Health
Wendy Larson	Quality Configuration Auditor, Senior, Elevance Health
Marianne Lynn	Compliance Manager, Elevance Health
Rodney Mack	Director, Strategic Vendor Management, Elevance Health
Kristen Mader	Provider Data Analyst Senior, Elevance Health
Caitlyn Marshall	Clinical Compliance Consultant, Elevance Health
LaShonda Mazique	Carelon Payment Integrity Manager, Elevance Health
Colleen McKinney	Planning and Performance Director, Elevance Health
Kathryn Morrison	Medicaid Quality Management Health Plan Director, Elevance Health
Krista Newton	Director, Care Coordination, Physician Health Partners
Erica Nissen	Supervisor, External Care Coordination Programs, Physician Health Partners
Michelle Norris	Compliance Manager, Elevance Health
Tony Olimpio	Manager, Member Engagement and Outreach Operations, Physician Health Partners
Monica Pacheco	Director II, Provider Relationship Account Management, Elevance Health
Marsha Penn	Manager, Behavioral Health Services, Elevance Health
Heather Pickell	Credentialing Specialist Lead, Elevance Health
Terri Piechocki	Account Management Executive Advisor, Elevance Health
Jillian Rivera	Peer Support Specialist Lead, Physician Health Partners
Abigail Roa	Director II, Compliance, Elevance Health
Leigh-Ann Rocha	Manager, Contracting and Regulatory, Physician Health Partners
Lisa Shevenell	Director I, Compliance, Elevance Health
Andrea Skubal	Accountable Care Network Program Manager, Physician Health Partners
Rachel Sundermeyer	Government Business Division, Finance Manager, Elevance Health
Cindi Terra	Director, Practice Transformation, Physician Health Partners
Lizbeth Villaruz	Internal Audit Manager, Elevance Health
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
Julie Zepeda Herrera	Medical Policy Analyst Senior, Elevance Health
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
	<p>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.</p> <p>For each element receiving a score of <i>Partially Met</i> or <i>Not Met</i>, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.</p>
Step 2	Prior approval for timelines exceeding 30 days
	<p>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.</p>
Step 3	Department approval
	<p>Following review of the CAP, the Department and HSAG will:</p> <ul style="list-style-type: none"> • 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
	<p>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.</p> <p>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.</p>

Step	Action
Step 5	Technical assistance
	<p>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.</p>
Step 6	Review and completion
	<p>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.</p> <p>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.</p> <p>HSAG will continue to work with the MCE until all required actions are satisfactorily completed.</p>

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for CCHA RAE 7

Standard IX—Subcontractual Relationships and Delegation
<input type="checkbox"/> Plan(s) of Action Complete <input type="checkbox"/> Plan(s) of Action on Track for Completion <input type="checkbox"/> Plan(s) of Action Not on Track for Completion
Requirement
<p>4. The written agreement with the subcontractor includes:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> – 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. <p style="text-align: right;"><i>42 CFR 438.230(c)(3)</i></p> <p>RAE Contract: Exhibit B-8—4.2.13.6</p>
Findings
<p>HSAG reviewed a sample of contracts across the delegated activities and found that some of the written agreements did not include the required language.</p>
Required Actions
<p>CCHA must ensure, via revisions or amendments, that all subcontractor agreements include the following required language:</p> <ul style="list-style-type: none"> • 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
<ul style="list-style-type: none">– 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
	<p>Before the review to assess compliance with federal managed care regulations and Department contract requirements:</p> <ul style="list-style-type: none"> HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. HSAG collaborated with the Department to develop 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
	<ul style="list-style-type: none"> HSAG attended the Department’s Integrated Quality Improvement Committee (IQiC) 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
	<ul style="list-style-type: none"> • 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
	<ul style="list-style-type: none"> • 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
	<ul style="list-style-type: none"> • 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.