COLORADO

Department of Health Care Policy & Financing

# Fiscal Year 2024–2025 Compliance Review Report

*for*

# Colorado Community Health Alliance

# Region 6

*April 2025*

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

HSAG HEALTH SERVICES ADVISORY GROUP

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## 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) showed a strong understanding of federal regulations, scoring 90 percent and above on all four standards. While the Standard III—Coordination and Continuity of Care score increased from the previous review period, the Standard VIII—Credentialing and Recredentialing overall score decreased by only 3 percentage points.

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

**Table 1-1—Summary of Scores for Standards**

| Standard | # of Elements | # of Applicable Elements | # Met | # Partially Met | # Not Met | # Not Applicable | Score* (% of Met Elements) |
|---|---|---|---|---|---|---|---|
| III. Coordination and Continuity of Care | 10 | 10 | 10 | 0 | 0 | 0 | 100%^ |
| IV. Member Rights, Protections, and Confidentiality | 6 | 6 | 6 | 0 | 0 | 0 | 100%~ |
| VIII. Credentialing and Recredentialing | 33 | 32 | 31 | 1 | 0 | 1 | 97%v |
| XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | 7 | 7 | 7 | 0 | 0 | 0 | 100%~ |
| **Totals** | **56** | **55** | **54** | **1** | **0** | **1** | **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.

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

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

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

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

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

| Record Reviews | # of Elements | # of Applicable Elements | # Met | # Not Met | # Not Applicable | Score* (% of Met Elements) |
|---|---|---|---|---|---|---|
| Credentialing | 90 | 73 | 73 | 0 | 17 | 100%~ |
| Recredentialing | 70 | 52 | 52 | 0 | 18 | 100%~ |
| **Totals** | **160** | **125** | **125** | **0** | **35** | **100%** |

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

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

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

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

## Standard III—Coordination and Continuity of Care

### *Evidence of Compliance and Strengths*

CCHA submitted comprehensive policies, procedures, program descriptions, workflows and other materials that outlined a range of deliberate care coordination programs and activities to support members' physical and behavioral health needs. CCHA described a robust care coordination team comprised of 86 diverse clinical and nonclinical professionals, including mental health clinicians, registered nurses, social workers, and peer support specialists dedicated to supporting members in Region 6.

While care coordination was available to all members, CCHA proactively outreached any member with an affirmative response to any question on the Health Needs Survey (HNS) administered by Health First Colorado. CCHA also used self-referrals, provider referrals, utilization management data, condition management programs, health needs assessments, and population-based triggers to identify members who could benefit from care coordination. Member Support Services (MSS) and care coordinators conducted outreach calls to ascertain care coordination needs. Members requiring ongoing support were assigned to specialized programs for care coordination: Adult Integrated Systems; Chronic Disease Management; Complex Care Management; Maternity; MSS; Outreach Care Specialist, Outreach Peer Specialist, and Peer Support Specialist; Pediatric-Foster Care; Transitions of Care; Behavioral Health Transitions of Care; Specialized Transitions of Care; and Justice-Involved. CCHA designates a single point of contact to lead care coordination based on the member's primary treatment needs and preference.

CCHA's policies and interview emphasized procedures for preventing service duplication and ensuring continuity of care across settings. Policies described performing complex case reviews, sharing member care plans, and communicating with the lead care coordinator and the providers involved in the member's care. CCHA described strong partnerships with case management agencies, local hospitals, and community mental health centers to further strengthen coordination of services across systems.

CCHA RAE 6 partners with five provider groups, referred to as Accountable Care Network (ACN) providers. ACN providers provide care coordination and outreach to assigned members. CCHA monitored ACN provider performance through timely report and data submissions, responsiveness to care coordination referrals, meeting attendance (including monthly ACN meetings, Performance Improvement Advisory Committee (PIAC) meetings, and special events), quarterly care coordination case audits, policy and procedure reviews, and performance on Key Performance Indicators (KPIs) and Provider Incentive Program metrics.

CCHA leverages a comprehensive electronic care coordination tool, Essette, to document all care coordination activities. This system captures member information, care plans, notes, goals, and interventions, and documents contact with members. CCHA provided evidence that Essette is accessible via mobile devices and adheres to privacy requirements.

### *Recommendations and Opportunities for Improvement*

HSAG identified no opportunities for improvement.

### *Required Actions*

HSAG identified no required actions.

## Standard IV—Member Rights, Protections, and Confidentiality

### *Evidence of Compliance and Strengths*

CCHA's Member Rights and Responsibilities Policy outlined member rights and responsibilities and how CCHA complies with applicable federal and State laws. CCHA's policies and staff members described that member rights are communicated to members through the Health First Colorado member handbook and on CCHA's website. The member handbook educated members of their right to participate in decisions concerning their healthcare, the right to receive information about treatment options and alternatives, the right to obtain a second opinion, and the right to file a grievance if the member feels their rights were violated. Annual trainings informed employees of member rights and applicable laws. During the interview, CCHA described that both clinical and nonclinical staff members are trained to ensure member rights are taken into consideration when providing services, including escalating any identified issues through the grievance or quality of care concern processes. CCHA further described that providers are made aware of members rights and responsibilities through the website, provider manual, provider newsletters, and for behavioral health providers, through new provider orientation.

CCHA's Privacy Policy discussed CCHA's measures for securing and transmitting protected health information (PHI), including how CCHA maintains adequate safeguards. During the interview, staff members described the annual trainings regarding the Health Insurance Portability and Accountability Act (HIPAA) and privacy requirements.

CCHA educated members, providers, and staff members on advanced directives through the advance directives policy, the member handbook, website, provider newsletters, and the provider manual. CCHA's website provided members and the community with detailed information on advance care planning, including but not limited to information about Medical Durable Power of Attorney (MDPOA), proxy decision makers, guardians, living wills, Five Wishes, and Colorado Medical Orders for Scope of Treatment (MOST).

### Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

### Required Actions

HSAG identified no required actions.

## Standard VIII—Credentialing and Recredentialing

### Evidence of Compliance and Strengths

CCHA demonstrated a comprehensive credentialing and recredentialing process that complies with National Committee for Quality Assurance (NCQA) standards. CCHA provided detailed descriptions of its credentialing department, associated software systems, credentialing committee structure, and the application review process. Throughout the interview, CCHA demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures. CCHA reported that although applications are processed internally, Sutherland Healthcare Solutions conducted the primary source verifications on all provider applicants.

CCHA's credentialing process included a thorough file verification. Clean files were approved by the medical director, while files with identified issues required in-depth review and discussion by the credentialing committee, which met monthly. Additionally, practitioners were notified within 60 calendar days of the decision. In conjunction, credentialing policies described how credentialing and recredentialing decisions are conducted in a nondiscriminatory manner. Further, CCHA submitted an annual nondiscriminatory review report as evidence that demonstrates how audits are conducted on credentialing files to ensure nondiscrimination. The audit report is presented to the Credentials Committee annually for discussion.

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

CCHA delegated credentialing and recredentialing activities to multiple contracted organizations. Annual monitoring of delegates was conducted by CCHA through a delegation audit, ensuring compliance with activities, responsibilities, and reporting.

### *Recommendations and Opportunities for Improvement*

HSAG identified no opportunities for improvement.

### *Required Actions*

CCHA submitted evidence of a credentialing policy posted to its website that was timestamped on the website as being updated on the day of the compliance review. That policy, however, did not meet the requirement for including information on how CCHA conducts provider retention. CCHA must develop a retention policy and make it available on its public website.

## Standard XI—EPSDT Services

### *Evidence of Compliance and Strengths*

CCHA implemented a multi-faceted approach to EPSDT outreach and education for newly enrolled Medicaid members and members who had not utilized services in the past 12 months. CCHA's efforts focused on pregnant women, EPSDT-eligible children, and their families or caregivers, adhering to the American Academy of Pediatrics (AAP) Bright Futures Guidelines. CCHA's overarching goal was to improve health outcomes, member satisfaction, and reduce healthcare costs through appropriate screening, preventive care utilization, education about Medicaid benefits and CCHA services, and ensure connections to necessary resources.

CCHA aimed to inform members about the EPSDT program within 60 days of pregnancy notification, initial Medicaid eligibility determination (or regained eligibility after a 12-month lapse), and annually for nonutilizers. While striving to reach all EPSDT-eligible members within a household, they were accountable for providing information at least once per household annually, with exceptions for eligibility changes within a 12-month period.

To engage members, CCHA employed diverse outreach methods, including text messaging, automated calls, email, mail, phone calls, face-to-face interactions, and video conferencing, with multiple attempts through various channels. CCHA followed best practices for outreach, such as varying contact times and collaborating with the Colorado Department of Health Care Policy & Financing (the Department) to refine strategies and target at-risk groups. CCHA identified interventions to connect with its Spanish speaking member population, including a campaign to text information in Spanish to members who self-report Spanish as their preferred language. CCHA provided a Spanish version of all EPSDT communication and facilitated a committee of Spanish-speaking members tasked with reviewing communication and outreach to ensure that it effectively explained the benefits of the EPSDT program

in plain language. CCHA provided EPSDT outreach information on preventive healthcare benefits, AAP Bright Futures Guidelines, available EPSDT services, service access, cost-free nature of EPSDT, and support for transportation and appointment scheduling.

CCHA ensured access to medically necessary behavioral health services for children under 21 years of age, adhering to EPSDT regulations and related guidance. CCHA provided or arranged for appropriate mental/behavioral health developmental screenings, ensuring qualified providers conducted the screenings in a culturally and linguistically sensitive manner, with proper documentation. Diagnostic services were offered in addition to treatment for conditions discovered through screening. Service limits under EPSDT were sufficient in amount, duration, and scope, and CCHA did not deny or reduce services supporting stability, functioning, or treatment progress. Medical necessity was determined through individualized clinical reviews. For services outside the behavioral health capitation, CCHA care coordination staff assisted members in accessing care.

CCHA monitored utilization to ensure children received regular physical and mental health examinations, growth and development assessments, and nutritional status evaluations. CCHA provided referrals to Title V programs like Head Start, the Women, Infants, and Children (WIC) nutrition program, and early intervention services for members needing additional support.

EPSDT updates were sent to community partners biannually. CCHA trained staff members on EPSDT procedures, and accessible information was available via trainings, the website, and materials. Network providers were informed about the EPSDT program through various channels, and CCHA assisted them in resolving access barriers. Trainings and updates were provided to network providers at least every six months.

## Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

## Required Actions

HSAG identified no required actions.

# 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 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 behavioral health providers to ensure access to care for Medicaid members. In accordance with Title 42 of the Code of Federal Regulations (42 CFR), RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). The 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, February 2023, and May 2024. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), HSAG.

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) 2024–2025 was calendar year (CY) 2024. This report documents results of the FY 2024–2025 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 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, RAE, and Department personnel who participated in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[1]

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

## Overview of FY 2024–2025 Compliance Monitoring Activities

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

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

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, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key 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 E 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 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

## Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the 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 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 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 2023–2024 compliance monitoring review.

## Summary of FY 2023–2024 Required Actions

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

Related to Standard V—Member Information Requirements, HSAG identified no required actions for this standard.

Related to Standard VII—Provider Selection and Program Integrity, HSAG identified no required actions for this standard.

Related to Standard IX—Subcontractual Relationships and Delegation, CCHA was required to complete one required action:

- Ensure, via revisions or amendments, that all subcontractor agreements include the following required language:
  - The State, CMS, the U.S. Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
    - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
    - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

- If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

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

## Summary of Corrective Action/Document Review

CCHA submitted a proposed CAP and final documentation in June 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to CCHA.

## Summary of Continued Required Actions

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

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members.<br><br>B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk members and ensure active management of high-cost and high-need members. The RAE ensures that care coordination:<br>• Is accessible to members.<br>• Is provided at the point of care whenever possible.<br>• Addresses both short- and long-term health needs.<br>• Is culturally responsive.<br>• Respects member preferences.<br>• Supports regular communication between care coordinators and the practitioners delivering services to members.<br>• Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems.<br>• Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs.<br>• Is documented, for both medical and non-medical activities. | **The following document outlines CCHA's policy related to care coordination to ensure consistent coordination of care for all members and is supported by the care coordination procedures outlined in the program descriptions below.**<br>• III.CCC.1_CCHA_Care Coordination Operating Policy, pgs. 1, 2, 3<br><br>**CCHA's Care Coordination Policy and program descriptions outline specific activities focused on acute, complex, and high-risk patients and ensures that care coordination is accessible, provided at the point of care, and respects member preferences. To reduce duplication and address gaps, CCHA has also defined specific partnerships and co-locations to support care coordinators in collaborating with other service providers.**<br>• III.CCC.1_CCHA Program Description - Adult Integrated Systems, entire document<br>• III.CCC.1_CCHA Program Description- Behavioral Health Transitions of Care (BTOC), entire document<br>• III.CCC.1_CCHA Program Descriptions - Chronic Disease Management, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *42 CFR 438.208(b)*<br><br>Contract Amendment 17: Exhibit B—11.3.1, 11.3.7 | • III.CCC.1_CCHA Program Description - Complex Care Coordination, entire document<br>• III.CCC.1_CCHA Program Description Justice Involved, entire document<br>• III.CCC.1_CCHA Program Description - Maternity, entire document<br>• III.CCC.1_CCHA Program Description - Member Support Services, entire document<br>• III.CCC.1_CCHA Program Description - Outreach Care Specialist, Outreach Peer Specialist, and Peer Support Specialist, entire document<br>• III.CCC.1_CCHA Program Description - Pediatric-Foster Care, entire document<br>• III.CCC.1_CCHA Program Description - Specialized Transitions of Care, entire document<br>• III.CCC.1_CCHA Program Description - Transitions of Care, entire document<br><br>**CCHA delegates care coordination to ACN providers for members that are attributed to ACN practices. The following documents outline care coordination requirements for ACN providers and how CCHA monitors those activities.** | |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.1_CCHA R6 ACN Agreement, Exhibit B, pgs. 20-29<br>• III.CCC.1_CCHA ACN Monitoring and Oversight Policy, pg. 1,2<br>• III.CCC.1_ACN Case Audit Template, entire document<br><br>**The following document provide ways in which the Providers will support, refer and work with CCHA to ensure the member's health care needs are met in a timely manner.**<br>• III.CCC.1_CCHA Physical Health Provider Manual, pg. 43<br>• III.CCC.1_ CCHA RAE Orientation Template. pg. 19<br>• III.CCC.1_CCHA Provider Newsletter November 2024, pg. 1,2<br>• III.CCC.1_CCHA R6 PCMP Agreement, pg. 3,4,8<br><br>**The following document provides an overview of the procedure to monitor call interactions with the Member Support Services team to ensure staff provide members with comprehensive information on benefits and respond to member questions accurately and in a timely manner.** | |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.1_Member Support Services Call Monitoring Procedure, entire document<br>• III.CCC.1_CCHA Call Monitoring Form, entire document<br><br>**The following document provides an overview of the Case Management Agency (CMA) Incentive Program, which incentivizes participating entities to help reduce duplication across the health continuum and control costs.**<br>• III.CCC.1_ Letter of Intent TRE, entire document<br>• III.CCC.1_TRE Case Management Agency Incentive Program Summary, entire document<br>• III.CCC.1_Letter of Intent ACMI, entire document<br>• III.CCC.1_ACMI Case Management Agency Incentive Program Summary, entire document<br>• III.CCC.1_ Letter of Intent Jefferson County - OLTC<br>• III.CCC.1_OLTC 2024 Case Management Agency Incentive Program Summary | |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2. The RAE ensures that each behavioral health member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member.<br>• The member must be provided information on how to contact the designated person or entity.<br>*42 CFR 438.208(b)(1)*<br><br>Contract Amendment 17: Exhibit B—None | **CCHA has implemented the following policies which outline requirements for ensuring each member has an ongoing source of care and that the member is informed of how to contact their designated person or entity**.<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pgs. 2, 3<br>• III.CCC.2_CCHA Member Support Services Policy, pgs. 2,3<br><br>**The following program description examples demonstrate that behavioral health members have an ongoing source of care appropriate to their needs and designates a lead care coordinator responsible for coordinating care.**<br>• III.CCC.1_CCHA Program Description-Behavioral Health Transitions of Care (BTOC), pg. 5<br>• III.CCC.1_CCHA Program Description - Specialized Transitions of Care (STOC), pg. 5<br>• III.CCC.2_Member URL - Maternity, entire document<br>• III.CCC.2_Maternity Screener, entire document<br><br>**The following document serves as a member guide, informing members of CCHA's care coordination services, and how to contact CCHA for assistance. It is available in** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **English and Spanish.**<br>• III.CCC.2_Map to Medicaid English, entire document<br>• III.CCC.2_Map to Medicaid Spanish, entire document<br><br>**The following document serves as a quick reference guide for members about accessing behavioral health services and is available in English and Spanish.**<br>• III.CCC.2_BH Reference Guide English, entire document<br>• III.CCC.2_BH Reference Guide Spanish, entire document<br><br>**Customizable enrollment cards are available to members in both English and Spanish. It can be completed by the member or their care coordinator and includes space to document their provider's name and number, and their Health First Colorado ID number**.<br>• III.CCC.2_CCHA R6 Member Enrollment Card English, entire document<br>• III.CCC.2_CCHA R6 Member Enrollment Card Spanish, entire document<br><br>**This insert provides information for members regarding CCHA's care coordination services**. | |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.2_CCHA CC Insert - English, entire document<br>• III.CCC.2_CCHA CC Insert - Spanish, entire document<br><br>**The following document provides an overview of the process CCHA uses to ensure that each behavioral health member has an ongoing source of care appropriate to their needs.**<br>• III.CCC.2_CCHA BH Utilization Management Manual, pgs. 9, 10 | |
| 3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP.<br><br>Contract Amendment 17: Exhibit B—6.8.1 | **The following document outlines CCHA's policy regarding reviewing attribution assignments**<br>• III.CCC.3_CCHA Member Attribution Review Policy, entire document<br><br>**CCHA's program description for the Member Support Services team outlines the procedure followed to support these attribution and assignment comparisons and member outreach.**<br>• III.CCC.1_CCHA Program Description - Member Support Services, pg. 5<br>• III.CCC.3_Initial Screening Assessment - PCP Questions, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 4. The RAE's care coordination activities will comprise:<br>• A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being.<br>• Activities targeted to specific members who require more intense and extensive assistance and include appropriate interventions.<br><br>Contract Amendment 17: Exhibit B—11.3.3 | **CCHA's Care Coordination Operating Policy ensures care coordination includes a range of deliberate and extended interventions to coordinate with other aspects of the health system. Emphasis is placed on members identified to be high-risk, high-need, or high-cost to ensure active management of these members.**<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pgs. 1,2<br><br>**Further, the following CCHA program descriptions, SEP and CCB memoranda of understanding (MOUs) and workflows, practice support materials, and PCMP agreements provide evidence of CCHA's efforts to coordinate with other aspects of the health system.**<br>**Program Descriptions:**<br>• III.CCC.1_CCHA Program Description - Adult Integrated Systems, entire document<br>• III.CCC.1_CCHA Program Description- Behavioral Health Transitions of Care (BTOC), entire document<br>• III.CCC.1_CCHA Program Descriptions - Chronic Disease Management, entire document<br>• III.CCC.1_CCHA Program Description - Complex Care Coordination, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.1_CCHA Program Description Justice Involved, entire document<br>• III.CCC.1_CCHA Program Description - Maternity, entire document<br>• III.CCC.1_CCHA Program Description - Member Support Services, entire document<br>• III.CCC.1_CCHA Program Description - Outreach Care Specialist, Outreach Peer Specialist, and Peer Support Specialist, entire document<br>• III.CCC.1_CCHA Program Description - Pediatric-Foster Care, entire document<br>• III.CCC.1_CCHA Program Description - Specialized Transitions of Care, entire document<br>• III.CCC.1_CCHA Program Description - Transitions of Care, entire document<br><br>**MOUs and Workflows:**<br>• III.CCC.4_TRE Health Neighborhood MOU, entire document<br>• III.CCC.4_TRE Workflow. entire document<br>• III.CCC.4_Adult Care Management Inc. Health Neighborhood MOU, entire document<br>• III.CCC.4_A&I Avenues Workflow, entire document<br>• III.CCC.4_Jefferson County Human Services Health Neighborhood MOU AMD 1_1.20.22, entire document | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.4_Jefferson County Human Services Health Neighborhood MOU AMD 2_9.9.24, entire document<br>• III.CCC.4_Jefferson County Workflow, entire document<br>• III.CCC.4_Rocky Mountain Human Services Health Neighborhood MOU, entire document<br>• III.CCC.4_Rocky Mountain Human Services Workflow, entire workflow<br>• III.CCC.4_Foothills Gateway Inc Health Neighborhood MOU, entire workflow<br>• III.CCC.4_Otero County Department of Human Services MOU, entire document<br><br>**Practice Support Materials:**<br>• III.CCC.4_CCHA PCMP Incentive Program, entire document<br>• III.CCC.4_CCHA ACN Incentive Program, entire document<br>• III.CCC.4_ADA Compliance for Participating Providers, entire document<br><br>**The following Community Incentive Program projects serve to help facilitate the appropriate delivery of health and social services to support member health and wellbeing.**<br>• III.CCC.4_Wee Cycle CIP Contracting Form, entire document | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.4_Mission Arvada of the Rising CIP Contracting Form, entire document<br>• III.CCC.4_Silver Key LOI, entire document<br>• III.CCC.4_A Precious Child LOI, entire document<br><br>**The following partnerships have focus on improving accessing services to immunizations and vaccinations for Latino, BIPOC, homebound members, and members residing in rural areas**<br>• III.CCC.4_Boulder County Public Health Community Network MOU, entire document<br>• III.CCC.4_Julissa Soto Health Equity Consultant, entire document | |
| 5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers.<br><br>The RAE implements procedures to coordinate services furnished to the member:<br>• Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.<br>• With the services the member receives from any other managed care plan. | **CCHA's policy on care coordination, in addition to the procedures outlined in the program descriptions below, ensures that care is coordinated between settings of care, with services members receive from any other managed care plan, with fee-for-service Medicaid, and with services from community providers.**<br>• III.CCC.1_CCHA_Care Coordination Operating Policy, pg. 2<br><br>**Further, CCHA's program descriptions and county collaborative management program (CMP) memorandums of understanding** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • With the services the member receives in fee-for-service (FFS) Medicaid.<br>• With the services the member receives from community and social support providers.<br>• Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community.<br><br>*Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings; and members residing in the community who are identified as at-risk for institutionalization.*<br><br>*42 CFR 438.208(b)(2)*<br><br>Contract Amendment 17: Exhibit B—14.1, 14.3, 11.3.10, 11.3.10.4.2.3, 11.3.20.2.1 | **(MOUs) outlined below provide evidence of CCHA's collaboration with social service provider and efforts to coordinate services furnished to members.**<br><br>**Program Descriptions:**<br>• III.CCC.1_CCHA Program Description - Adult Integrated Systems, entire document<br>• III.CCC.1_CCHA Program Description - Behavioral Health Transitions of Care (BTOC), entire document<br>• III.CCC.1_CCHA Program Description - Chronic Disease Management, entire document<br>• III.CCC.1_CCHA Program Description - Complex Care Coordination, entire document<br>• III.CCC.1_CCHA Program Description - Justice Involved, entire document<br>• III.CCC.1_CCHA Program Description - Maternity, entire document<br>• III.CCC.1_CCHA Program Description - Member Support Services, entire document<br>• III.CCC.1_CCHA Program Description - Outreach Care Specialist and Peer Support Specialist, entire document<br>• III.CCC.1_CCHA Program Description - Pediatrics - Foster Care, entire document | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.1_CCHA Program Description - Specialized Transitions of Care (STOC), entire document<br>• III.CCC.1_CCHA Prog Description - Transitions of Care, entire document<br><br>**CMP MOUs:**<br>• III.CCC.5_Boulder County CMP MOU, entire document<br>• III.CCC.5_ Broomfield CMP MOU, entire document<br>• III.CCC.5_El Paso County CMP MOU, entire document<br>• III.CCC.5_Park County CMP MOU, entire document<br>• III.CCC.5_Clear Creek County CMP MOU, entire document<br>• III.CCC.5_Jefferson County CMP MOU, entire document<br>• III.CCC.5_Teller County CMP MOU, entire document<br><br>**CCHA collaborates with other RAE's, community partners, and health neighborhoods to ensure that there are no GAPS of services for members transitioning out of inpatient, incarceration, residential and institutional settings.** | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.5_Desktop Guide for RAE-to-RAE Transfers, entire document<br>• III.CCC.5_CCHA BH Transitions of Care Policy, entire document<br>• III.CCC.5_Ascent Health MOU, entire document<br>• III.CCC.5_CMA-RAE Cross Agency Forum Guidelines, entire document<br>• III.CCC.5_Skilled Nursing Facility Pathways, entire document<br><br>**Additionally, CCHA outreaches and provides Care Coordination services to Members identified as at-risk for institutionalization to support them in remaining in the community including care transition support, and referrals to HCBS services.**<br>• III.CCC.5_4th Judicial Probation, HN MOU, entire document<br>• III.CCC.5_Forensic Services MOU, entire document<br>• III.CCC.5_Hospital Discharge Status Report Summary, entire document<br>• III.CCC.5_HCBS and CMA Pathways - Adult Waivers, entire document<br><br>**CCHA distributes the following referral forms to providers and community partners as a** | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **vehicle to refer members to CCHA for care coordination.**<br>• III.CCC.5_R6 Care Coordination Referral Form, entire document | |
| 6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE:<br>• Processes a daily data transfer from the Department containing responses to member health needs surveys.<br>• Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE.<br>*42 CFR 438.208(b)(3)*<br>Contract Amendment 17: Exhibit B—7.5.2–3 | **This workflow documents CCHA's process for daily intake of health needs survey data from HCPF and the process for outreaching the member.**<br>• III.CCC.6_CCHA Enrollment Broker Health Needs Survey Policy, entire document<br>**CCHA's Member Support Services Policy includes information on the health needs survey outreach campaign.**<br>• III.CCC.2_CCHA Member Support Services Policy, pg. 2<br>**CCHA uses the following health need assessments to help identify members who may need additional support**<br>• III.CCC.6_Peds HNA, entire document<br>• III.CCC.6_Adult HNA, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 7. *For the Capitated Behavioral Health Benefit:*<br>The RAE ensures that it has procedures to ensure:<br>• Each member receives an individual intake and assessment appropriate for the level of care needed. | **CCHA's Care Coordination and Member Support Services policies outline expectations for intake and assessment of members.**<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pg. 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • It uses the information gathered in the member's intake and assessment to build a service plan.<br>• It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems.<br><br>*42 CFR 438.208(c)(2–3)*<br><br>Contract Amendment 17: Exhibit B—14.7.1 | • III.CCC.2_CCHA Member Support Services Policy, pg. 2<br><br>**CCHA's program descriptions include procedures to provide an intake and assessment to determine member needs and gather information to build a care plan and includes mechanisms to collaborate with other members of the care team when members are involved in multiple systems and facilitate transitions in care. An example is provided below.**<br>• III.CCC.1_CCHA Program Description - Pediatric-Foster Care, pg. 5<br><br>**The following sample letter is used by care coordination to engage with other providers serving a member.**<br>• III.CCC.7_CCHA RAE PCP Collaboration Letter - Case Open, entire document<br>• III.CCC.7_CCHA RAE PCP Collaboration Letter - Case Update, entire document<br>• III.CCC.7_CCHA RAE PCP Collaboration Letter - Case Closure, entire document<br><br>**This requirement is evidenced by CCHA's care coordination assessments, samples of which are provided below.**<br>• III.CCC.6_Peds HNA, entire document<br>• III.CCC.6_Adult HNA, entire document | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.7_ Member Benefits, entre document<br>• III.CCC.7_Diabetes Screener, entire document<br>• III.CCC.7_Maternity Assessment, entire document<br>• III.CCC.7_BTOC Tracker, entire document<br>• III.CCC.7_STOC Tracker, entire document<br><br>**CCHA's Behavioral Health Provider Manual defines requirements for each member to receive an intake assessment, for a care plan to be built based on the intake assessment findings, and for continuity of care.**<br>• III.CCC.7_BH Provider Manual, pgs. 21-24, 76, 78-79<br><br>**The following MOUs are examples of partnerships with community entities to coordinate and provide continuity of care for members who are involved in the justice system as they experience service transitions.**<br>• III.CCC.5_Ascent Health MOU, entire document<br>• III.CCC.5_Forensic Services MOU, entire document<br>• III.CCC.5_4th Judicial Probation, HN MOU, entire document | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 8. *For the Capitated Behavioral Health Benefit:*<br>The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities.<br><br>*42 CFR 438.208(b)(4)*<br><br>Contract Amendment 17: Exhibit B—None | **CCHA's Care Coordination Operating Policy includes a statement that CCHA shares information about a member's needs with other entities serving the member to prevent duplication of services.**<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pg. 2<br>• III.CCC.2_CCHA Member Support Services Policy, pg. 2<br><br>**The following sample letter is used by care coordination to engage with other providers serving a member.**<br>• III.CCC.7_CCHA RAE PCP Collaboration Letter - Case Open, entire document<br>• III.CCC.7_CCHA RAE PCP Collaboration Letter - Case Update, entire document<br>• III.CCC.7_CCHA RAE PCP Collaboration Letter - Case Closure, entire document<br><br>**The following documents are examples of different ways in which CCHA shares member data with other entities to prevent duplication of services.**<br>**Program Descriptions**<br>• III.CCC.1_CCHA Program Description-Behavioral Health Transitions of Care (BTOC)<br>• Desktop Guide for Sharing information with Comprehensive Safety Net Providers (CSNPs) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **Housing Collaboration**<br>• III.CCC.8_COHMIS Agency Partnership Agreement Version 2.0, entire document | |
| 9. *For the Capitated Behavioral Health Benefit:*<br>The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable.<br>*42 CFR 438.208(b)(5) and (6)*<br>Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5 | **The following behavioral health provider agreement template outlines CCHA's expectations for maintaining and sharing member health records and protecting member privacy.**<br>• III.CCC.9_CCHA BH Provider Contract Template, pg. 6,7<br><br>**CCHA's Behavioral Health Provider Manual outlines requirements for maintaining member health records and protecting member privacy.**<br>• III.CCC.7_BH Provider Manual, pgs. 86-87, 96-99<br><br>**The following PCMP provider agreement template outlines CCHA's expectations for maintaining and sharing member health records and protecting member privacy**<br>• III.CCC.1_CCHA R6 PCMP Agreement, pg. 12, 13<br><br>**CCHA's Physical Health Provider Manual outlines requirements for maintaining** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **member health records and protecting member privacy.**<br>• III.CCC.9_CCHA Physical Health Provider Manual, pg. 34<br><br>**The following policy includes a statement that CCHA ensures that each member's privacy is protected in the process of coordinating care, in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent they are applicable.**<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pgs. 2, 3<br><br>**The following policy acknowledges members' right to have their medical record and information protected in accordance with HIPAA and all other applicable privacy laws.**<br>• III.CCC.9_Member Rights and Responsibilities Policy, pg. 3<br><br>**The following policy includes the provision that CCHA will reasonably ensure that personnel only have access to and share the minimum amount of information necessary to conduct business where PHI is used or disclosed and will protect member privacy in accordance with HIPAA.**<br>• III.CCC.9_CCHA Privacy Policy, pg. 4 | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **CCHA uses the following release of information form to document member consent and specifications around sharing the member's protected health information**<br>• III.CCC.9_CCHA Authorization to Release Health Information English, entire document<br>• III.CCC.9_CCHA Authorization to Release Health Information Spanish, entire document<br><br>**CCHA uses the following form to determine whether an agency may be a Covered Entity, with whom CCHA may share PHI without a specific release in accordance with HIPAA.**<br>• III.CCC.9_Covered Entity Form, entire document | |
| 10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum:<br>• Name and Medicaid ID of member for whom care coordination interventions were provided.<br>• Age.<br>• Gender identity.<br>• Race/ethnicity. | **The following screenshot from CCHA's electronic care coordination tool demonstrate the ability to collect member name, Medicaid ID, age, gender, name of entity/person providing care coordination, designated lead care coordinator, other entities servicing the member, stratification level, assessments, care plan goals, tasks, notes, and correspondence**<br>• III.CCC.10_Essette Screen Shots, entire document<br>• III.CCC.10_CCHA Essette Front End Report, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators.<br>• Care coordination notes, activities, and member needs.<br>• Stratification level.<br>• Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals.<br><br>The care coordination tool, at a minimum:<br>• Works on mobile devices.<br>• Supports HIPAA and 42 CFR Part 2 compliant data sharing.<br>• Provides role-based access to providers and care coordinators.<br><br>*Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.*<br><br>Contract Amendment 17: Exhibit B—15.2.1.1, 15.2.1.2, 15.2.1.3–5 | **CCHA's Care Coordination Operating Policy includes the provision that care coordination activities and member information are documented in Essette**.<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pgs. 2,3<br><br>**The following health needs assessments demonstrate collection of information that can be used to create a care plan and goals for the member. These assessments also collect the member's self-reported race and identifies the lead care coordinator.**<br>• III.CCC.6_Peds HNA, entire document<br>• III.CCC.6_Adult HNA, entire document<br><br>**The following documents demonstrate use of delegation tools that demonstrate collection of member information and use in accordance with HIPAA and data sharing.**<br>• III.CCC.7_BH Provider Manual, pg. 81<br>• III.CCC.1_CCHA Care Coordination Operating Policy, pgs. 2,3<br>• III.CCC.1_CCHA R6 ACN Agreement, pgs. 20-29<br>• III.CCC.1_ACN Case Audit Template. entire document | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • III.CCC.1_CCHA R6 PCMP Agreement, pg. 12 | |

| Results for Standard III—Coordination and Continuity of Care | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 10 | X | 1.00 | = | 10 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 10 | **Total Score** | | = | 10 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 100% |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The RAE has written policies regarding the member rights specified in this standard.<br><br>*42 CFR 438.100(a)(1)*<br><br>Contract Amendment 17: Exhibit B—7.3.7.1–2 | **The following are all related to the member rights and protections specified in this standard:**<br>• IV.MRP.1_ADA Compliance for Participating Providers Policy, entire document<br>• IV.MRP.1_Member and Provider Materials and Website Policy, entire document<br>• IV.MRP.1_Member Rights and Responsibilities Policy, entire document<br>• IV.MRP.1_Privacy Policy, entire document<br>• IV.MRP.1_Member Grievances Policy, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights.<br><br>*42 CFR 438.100(a)(2) and (d)*<br><br>Contract Amendment 17: Exhibit B—17.10.7.2 | **The following policy informs employees of applicable member rights and their duty to observe and protect said rights. The attestations demonstrate that all member-facing staff completed this annual training.**<br>• IV.MRP.1_Member Rights and Responsibilities Policy, Pg 2<br>• IV.MRP.2_Attestation for Compliance Training - BH Care Coordination, entire document<br>• IV.MRP.2_Attestation for Compliance Training - Care Coordination and Member Support Services, entire document<br>• IV.MRP.2_Attestation for G&A, QOC, and Member Rights Training - Care Coordination, entire document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • IV.MRP.2_Attestation for G&A, QOC, and Member Rights Training - Member Support Services, entire document<br><br>**The Physical and Behavioral Health Provider Manuals inform network providers of member rights and responsibilities:**<br>• IV.MRP.2_BH Provider Manual, pgs. 109-112<br>• IV.MRP.2_PH Provider Manual, pgs. 14-17<br><br>**The CCHA website provides members with information regarding member rights and their ability to exercise said rights without retaliation. Additionally, CCHA provides a link to the Health First Colorado Member Handbook to learn more.**<br>• https://www.cchacares.com/for-members/member-benefits-services/<br>• https://www.cchacares.com/for-members/frequently-asked-questions/<br>• https://www.cchacares.com/for-members/get-help/<br><br>**To further inform the provider network, CCHA published the member rights and responsibilities in the Provider Newsletter:**<br>• IV.MRP.2_Provider Newsletter - Member Rights, Pg 2 | |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 3. The RAE's policies and procedures ensure that each member is guaranteed the right to:<br>• Receive information in accordance with information requirements (42 CFR 438.10).<br>• Be treated with respect and with due consideration for the member's dignity and privacy.<br>• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.<br>• Participate in decisions regarding their health care, including the right to refuse treatment.<br>• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.<br>• Request and receive a copy of their medical records and request that they be amended or corrected.<br>• Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210).<br>*42 CFR 438.100(b)(2) and (3)*<br><br>Contract Amendment 17: Exhibit B—7.3.7.2.1–6 | **The following policy contains the member rights found in this requirement:**<br>• IV.MRP.1_Member Rights and Responsibilities Policy, pgs. 2-4<br><br>**The following policy provides information on an individual's right to access PHI as contained in a designated record set, as well as information regarding a member's right to amend their PHI:**<br>• IV.MRP.1_Privacy Policy, pgs. 8, 14<br><br>**The following document outlines the policy for an individual to request access to or a copy of their PHI in a designated record set maintained by CCHA, along with the procedure to approve or deny a request:**<br>• IV.MRP.3_Individual Access to Designated Record Set Policy, entire document<br><br>**The following documents are examples of documents available to members that meet the requirements set forth in 42 CFR 438.10:**<br>• IV.MRP.3_Member Enrollment Card - R6 Spanish, entire document<br>• IV.MRP.3_Member Enrollment Card - R6, entire document<br><br>**The CCHA website provides members with information regarding member rights and their ability to exercise said rights without retaliation:** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • https://www.cchacares.com/for-members/frequently-asked-questions/<br>• https://www.cchacares.com/for-members/get-help/ | |
| 4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the RAE, its network providers, or the Department treat(s) the member.<br>*42 CFR 438.100(c)*<br>Contract Amendment 17: Exhibit B—7.3.7.2.7 | **The following policy includes the right for members to use their rights without fear of being treated poorly. CCHA staff will always work with HCPF, network providers, and the member to ensure the member's rights are preserved and the member is not adversely impacted in any way due to exercising said rights.**<br>• IV.MRP.1_Member Rights and Responsibilities Policy, Pg 2<br><br>**The CCHA website provides members with information regarding member rights and their ability to exercise said rights without retaliation. Additionally, CCHA provides a link to the Health First Colorado Member Handbook to learn more.**<br>• https://www.cchacares.com/for-members/member-benefits-services/<br>• https://www.cchacares.com/for-members/frequently-asked-questions/<br>• https://www.cchacares.com/for-members/appeals-and-grievances/<br>• https://www.cchacares.com/for-members/member-benefits-services/grievance-form/<br>• https://www.cchacares.com/for-members/get-help/ | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook<br><br>**The following document informs members that they may change their primary care provider at any time and directs them how to do so:**<br>• IV.MRP.4_Change PCP Card, entire document<br><br>**The Provider Manuals provide information regarding member rights to CCHA network providers.**<br>• IV.MRP.2_BH Provider Manual, pg. 111<br>• IV.MRP.2_PH Provider Manual, pg. 14 | |
| 5. For medical records and any other health and enrollment information that identify a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.<br>*42 CFR 438.224*<br><br>Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5 | **The following policy demonstrates compliance with this requirement by outlining CCHA's policies regarding member privacy and member PHI, including the confidentiality of patient information, the use and disclosure of member PHI where authorization is not required, and the use and disclosure of member PHI where authorization is required:**<br>• IV.MRP.1_Privacy Policy, pg. 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: | **The following policy demonstrates CCHA's responsibilities towards its members, providers, and staff regarding advance directives, and contains all the requirements required by the contract and federal regulations:** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Notice that members have the right to request and obtain information about advance directives at least once per year.<br>• A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience.<br>– The difference between institution-wide conscientious objections and those raised by individual physicians.<br>– Identification of the State legal authority permitting such objection.<br>– Description of the range of medical conditions or procedures affected by the conscientious objection.<br>• Provisions:<br>– For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information.<br>– For providing advance directive information to the incapacitated member once he or she is no longer incapacitated.<br>– To document in a prominent part of the member's medical record whether the member has executed an advance directive. | • IV.MRP.6_Advance Directives Policy, entire document<br><br>**The following documents demonstrates that CCHA's Care Coordination staff received advance directives training:**<br>• IV.MRP.6_Attestation for Advance Directives Training - Care Coordination, entire document<br>• IV.MRP.6_Attestation for Advance Directives Training - Member Support Services, entire document<br><br>**CCHA's December 2021 Provider Newsletter included an article to educate network providers and community partners on advance care planning and available resources:**<br>• IV.MRP.6_Provider Newsletter - Advance Care Planning, pg. 8<br><br>**Information regarding advance directives is provided to behavioral health providers via the provider manual:**<br>• IV.MRP.2_BH Provider Manual, pgs. 97-98<br><br>**Information regarding advance directives is provided to physical health providers via the provider manual:**<br>• IV.MRP.2_PH Provider Manual, pgs. 16, 25, 35-36 | |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive.<br>– To ensure compliance with State laws regarding advance directives.<br>– To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment.<br>– To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law.<br>– To educate staff concerning its policies and procedures on advance directives.<br>– The components for community education regarding advance directives that include:<br>▪ What constitutes an advance directive.<br>▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment.<br>▪ Description of applicable State law concerning advance directives.<br><br>*Note: The RAE must be able to document its community education efforts.*<br><br>*42 CFR 438.3(j)* | **The following documents serve as resource guides for members and provides information on how CCHA can support advance care planning:**<br>• IV.MRP.6_Advance Care Planning Resources, entire document<br>• IV.MRP.6_Advance Care Planning Resources - Spanish, entire document<br>• IV.MRP.6_Five Wishes Flyer, entire document<br>• IV.MRP.6_Advance Care Planning Poster - Spanish, entire document<br>• IV.MRP.6_Advance Care Planning Poster, entire document<br><br>**The following program description is an example that demonstrates that CCHA's care coordinators provide education to members and their families about advance directive options and tools, when appropriate:**<br>• IV.MRP.6_Prog Description - CCHA Complex Care Management, pgs. 6-7<br><br>**CCHA's website provides information to members regarding advance directives and provides a link to the Health First Colorado Member Handbook for additional information:**<br>• IV.MRP.6_CCHA Website - Advance Care Planning, entire document<br>• IV.MRP.6_CCHA Website - Advance Care Planning Spanish, entire document | |

| Standard IV—Member Rights, Protections, and Confidentiality | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *42 CFR 422.128*<br><br>Contract Amendment 17: Exhibit B—7.3.11.2, 7.3.11.3.3 | • IV.MRP.6_Health First Colorado Member Handbook - Spanish, pg. 13<br>• IV.MRP.6_Health First Colorado Member Handbook, pg. 13<br>• https://www.healthfirstcolorado.com/benefits-services/?tab=member-handbook<br>• https://www.cchacares.com/for-members/get-help/<br>• https://www.cchacares.com/for-members/advance-care-planning/<br>• https://www.cchacares.com/for-members/frequently-asked-questions/ | |

| Results for Standard IV—Member Rights, Protections, and Confidentiality | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 6 | X | 1.00 | = | 6 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 6 | **Total Score** | | = | 6 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 100% |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.<br>• The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers.<br>*42 CFR 438.214(b)*<br>NCQA CR1<br>Contract Amendment 17: Exhibit B—9.3.5.2.1 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pg 1 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify:<br>2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor.<br>The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers.<br>*Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists,* | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pg 2 | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *master's level clinical social workers, master's level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*<br><br>*42 CFR 438.214(a)–(b)(1)*<br><br>NCQA CR1—Element A1<br>Contract Amendment 17: Exhibit B—9.1.6 | | |
| **Findings:**<br>CCHA submitted evidence of a credentialing policy posted to its website that was timestamped on the website as being updated on the day of the compliance review. That policy, however, did not meet the requirement for including information on how CCHA conducts provider retention. | | |
| **Required Actions:**<br>CCHA must incorporate a section in its current credentialing policy or develop a standalone policy for how CCHA retains providers and make the policy available on its public website. | | |
| 2.B. The verification sources it uses.<br><br>NCQA CR1—Element A2 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pgs 5 & 6<br><br>VIII_CR_CCHA_Req2B_Policy 6v8_Process for Verification of Data Elements. Pgs 4, 5, 6 - 10 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.C. The criteria for credentialing and recredentialing.<br><br>NCQA CR1—Element A3 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pgs 8 - 17 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.D. The process for making credentialing and recredentialing decisions.<br><br>NCQA CR1—Element A4 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pgs 3 & 4, 9 - 17 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria.<br><br>NCQA CR1—Element A5 | VIII_CR_CCHA_Req2E_Policy 8v9_Credentialing Leveling&Committee, pgs 1-8 & 10-11 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.<br><br>*Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.*<br><br>*42 CFR 438.214(c)*<br><br>NCQA CR1—Element A6 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pg 5 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor.<br><br>NCQA CR1—Element A7 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision.<br><br>NCQA CR1—Element A8 | VIII_CR_CCHA_Req2H_Policy 3v11_Credentials Committee pgs 8 and 9 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program.<br><br>NCQA CR1—Element A9 | VIII_CR_CCHA_Req2I_Policy 3v11_Credentials Committee pgs 1, 3 and 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.<br><br>NCQA CR1—Element A10 | VIII_CR_CCHA_1-2K_2024 Credentialing Policy pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, | VIII_CR_CCHA_1-2K_2024 Credentialing Policy, pg 11 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| training, certification (including board certification, if applicable) and specialty.<br><br>NCQA CR1—Element A11 | | |
| 3. The Contractor notifies practitioners about their rights:<br><br>3.A. To review information submitted to support their credentialing or recredentialing application.<br><br>*The Contractor is not required to make references, recommendations, or peer-review protected information available.*<br><br>NCQA CR1—Element B1 | VIII_CR_CCHA_.3_Credentialing Policy, pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 3.B. To correct erroneous information.<br><br>NCQA CR1—Element B2 | VIII_CR_CCHA_.3_Credentialing Policy, pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 3.C. To receive the status of their credentialing or recredentialing application, upon request.<br><br>NCQA CR1—Element B3 | VIII_CR_CCHA_.3_Credentialing Policy, pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions.<br><br>NCQA CR2 | VIII_CR_CCHA_4-9_Credentialing Policy, pgs 3 & 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 5. The Credentialing Committee:<br>• Uses participating practitioners to provide advice and expertise for credentialing decisions.<br>• Reviews credentials for practitioners who do not meet established thresholds.<br>• Ensures that clean files are reviewed and approved by a medical director or designated physician.<br><br>NCQA CR2—Element A1–3 | VIII_CR_CCHA_4-9_Credentialing Policy, pgs 3 & 4, 5 & 16 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.:<br>• A current, valid license to practice (verification time limit is 180 calendar days).<br>• A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision).<br>• Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing | VIII_CR_CCHA_4-9_Credentialing Policy, pgs 5, 6, & 9 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| decision; if board certification, time limit is 180 calendar days).<br>• Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days).<br>– If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing.<br>• History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days).<br>– The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship.<br>*Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.*<br>NCQA CR3—Element A | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days):<br>• State sanctions, restrictions on licensure, or limitations on scope of practice.<br>• Medicare and Medicaid sanctions.<br>*42 CFR 438.214(d)(1)*<br>NCQA CR3—Element B | VIII_CR_CCHA_4-9_Credentialing Policy, pgs 6, 8, 9, 16 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 8. Applications for credentialing include the following (attestation verification time limit is 365 days):<br>• Reasons for inability to perform the essential functions of the position, with or without accommodation.<br>• Lack of present illegal drug use.<br>• History of loss of license and felony convictions.<br>• History of loss or limitation of privileges or disciplinary actions.<br>• Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate).<br>• Current and signed attestation confirming the correctness and completeness of the application.<br>NCQA CR3—Element C | VIII_CR_CCHA_4-9_Credentialing Policy, pgs 5, 9 &11 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 9. The Contractor formally recredentials its practitioners within the 36-month time frame.<br><br>NCQA CR4 | VIII_CR_CCHA_4-9_Credentialing Policy, pg 17 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including:<br>• Collecting and reviewing Medicare and Medicaid sanctions.<br>• Collecting and reviewing sanctions or limitations on licensure.<br>• Collecting and reviewing complaints.<br>• Collecting and reviewing information from identified adverse events.<br>• Implementing appropriate interventions when it identifies instances of poor quality related to the above.<br><br>*42 CFR 438.214(d)(1)*<br><br>NCQA CR5—Element A | VIII_CR_CCHA_10-14_Credentialing Policy, pgs 6 & 7 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include:<br>• The range of actions available to the Contractor.<br>• Making the appeal process known to practitioners. | VIII_CR_CCHA_10-14_Credentialing Policy, pg 7 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.*<br><br>NCQA CR6—Element A | | |
| 12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter:<br><br>12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies.<br><br>*Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.*<br><br>*42 CFR 438.214(d)(1)*<br><br>NCQA CR7—Element A1 | VIII_CR_CCHA_10-14_Credentialing Policy, pgs 5, 6, 17 & 18 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body.<br><br>*Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.*<br><br>NCQA CR7—Element A2 | VIII_CR_CCHA_10-14_Credentialing Policy, pg 6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited.<br><br>*Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.*<br><br>*The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)*<br><br>NCQA CR7—Element A3 | VIII_CR_CCHA_10-14_Credentialing Policy, pg 17 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 13. The Contractor's organizational provider assessment policies and processes includes:<br>• For behavioral health, facilities providing mental health or substance abuse services in the following settings:<br>– Inpatient<br>– Residential<br>– Ambulatory<br><br>NCQA MBHO CR7—Elements B and C | VIII_CR_CCHA_10-14_Credentialing Policy, pg 2 & 3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 14. The Contractor has documentation that it assesses providers every 36 months.<br><br>NCQA MBHO CR7—Elements D and E | VIII_CR_CCHA_10-14_Credentialing Policy, pg 17 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 15. The RAE shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department.<br><br>Contract Amendment 17: B-13—9.1.6.5.5 | VIII_CR_CCHA_Req15_Monthly RAE Accountability Report_November 2024 Submission 10.01.2024-10.31.2024 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| 16. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that:<br>• Is mutually agreed upon. | The following documents are a mutually agreed upon contract which outlines the duties and responsibilities of the delegates.<br><br>*VIII.CR.21_CU Medicine Delegated Credentialing Agreement, entire document* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Describes the delegated activities and responsibilities of the Contractor and the delegated entity.<br>• Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom).<br>• Describes the process by which the Contractor evaluates the delegated entity's performance.<br>• Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making.<br>• Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement.<br><br>NCQA CR8—Element A | *VIII.CR.21_Denver Heatlh 2005 Contract Delegation Agreement, entire document*<br>*VIII.CR.21_Lifestance Health Delegation Agreement, entire document*<br>*VIII.CR.21_Parkview Ancillary Svs_Delegated Credentialing Agreement, entire document*<br>*VIII.CR.21_Sutherland_MSA-FINAL_Executed, entire document* | |
| 17. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began.<br><br>*The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.*<br><br>NCQA CR8—Element B | The following documents outline the pre-delegation audit with CAQH prior to delegation starting as well as the post go-live audit that was completed after delegation began. These audits reviewed NCQA, Federal, State, and Contract requirements.<br><br>*VIII.CR.22_CAQH Cred PGL 2024, entire document*<br>*VIII.CR.22_CAQH Cred Pre-Del 2023, entire document* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 18. For delegation agreements in effect 12 months or longer, the Contractor:<br>• Annually reviews its delegate's credentialing policies and procedures.<br>• Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect.<br>• Annually evaluates delegate performance against its standards for delegated activities.<br>• Semiannually evaluates regular reports specified in the written delegation agreement.<br>• At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures.<br>• At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.<br><br>NCQA CR8—Element C | The following document outlines the process for auditing delegates as well as the frequency and corrective action process.<br><br>*VIII.CR.23_EDOM GBD Policy, pg 11-19*<br><br>The following documents are annual audits that have been completed for delegates that have been active for longer than 12 months. These audits monitor Federal, State, NCQA and Contract requirements.<br><br>*VIII.CR.23_LifeStance Health AA 2024 Cred, pg 1, pg 2-23, pg 24-27*<br>*VIII.CR.23_Parkview AA 2024 Cred , pg 1, pg 2-22, pg 23*<br>*VIII.CR.23_Denver Health AA 2024 Cred , pg 1, pg 2-23, pg 24-27*<br>*VIII.CR.23_CU Medicine AA 2024 Cred, pg 1, pg 2-29, pg 30-36* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable.<br><br>NCQA CR8—Element D | The following document outlines deficiencies identified in the annual audit and the steps taken to resolve them.<br><br>*VIII.CR.24_CU Medicine CAP 2024 Cred, entire document* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Results for Standard VIII—Credentialing and Recredentialing | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 31 | X | 1.00 | = | 31 |
| | Partially Met | = | 1 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 1 | X | NA | = | NA |
| **Total Applicable** | | = | 32 | **Total Score** | | = | 31 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 97% |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The RAE onboards and informs members and their families regarding the services provided by EPSDT. This includes:<br>• Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant.<br>• At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care."<br>• Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance.<br><br>Contract Amendment 17: Exhibit B—7.3.12.1, 7.6.2 | **The following document outlines CCHA's policy and procedure related to EPSDT, which includes providing information to members and their families regarding EPSDT benefits and how to obtain additional information.**<br>• XI.EPSDT.1_EPSDT Policy, pgs. 3-4<br><br>**The following care coordination program descriptions outline care coordination activities for pediatric, foster care and maternity populations, including activities to inform members and their families regarding EPSDT benefits.**<br>• XI.EPSDT.1_CCHA Program Description - Pediatrics, pg. 6<br>• XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 7-8<br><br>**CCHA's member-facing staff received training on EPSDT benefits and services, and how CCHA can assist members to ensure members are appropriately educated of the availability of such services.**<br>• XI.EPSDT.1_EPSDT Staff Training Log - UM & CC<br>• XI.EPSDT.1_EPSDT Staff Training Log - MSS<br><br>**CCHA's website includes information to inform members and their families of EPSDT benefits, where services are available, how to obtain said services, and how to request transportation.** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | XI.EPSDT.1_Member URLs, specifically:<br>• https://www.cchacares.com/for-members/frequently-asked-questions<br>• https://www.cchacares.com/for-members/get-help<br>• https://www.cchacares.com/for-members/epsdt<br><br>**The following document demonstrates CCHA's processes to outreach both new enrollees and non-utilizer members to inform them of EPSDT benefits available to them.**<br>• XI.EPSDT.1_EPSDT Outreach Workflow, entire document<br><br>**The following audit templates assess CCHA's and ACNs documentation of EPSDT education and provision of EPSDT related resources.**<br>• XI.EPSDT.1_ Essette Audit Tool<br>• XI.EPSDT.1_ACN Audit Tool<br><br>**The following EPSDT Annual Plan reports define CCHA's strategic approach to meet the EPSDT outreach responsibilities.**<br>• XI.EPSDT.1_R6_EPSDT Strategy Plan, pg. 2-3 | |
| 2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services:<br>• Mailed letters, brochures, or pamphlets | **The following policy includes a statement regarding having multiple methods of outreach, using a combination of written and oral materials.**<br>• XI.EPSDT.1_EPSDT Policy, pg.4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Face-to-face interactions<br>• Telephone or automated calls<br>• Video conferencing<br>• Email, text/SMS messages<br><br>Contract Amendment 17: Exhibit B—7.6.6 | **The following documents include information regarding care coordination services being delivered through multiple modalities, including in-person, telephonic, video, email, text message, and other forms as appropriate.**<br>• XI.EPSDT.1_CCHA Program Description - Pediatrics, pg. 4<br>• XI.EPSDT.1_CCHA Program Description - Maternity, pg. 6<br><br>**The following policy states the requirement that CCHA will provide all required member information to members in a manner and format that may be easily understood and is readily accessible by members.**<br>• XI.EPSDT.2_ Member and Provider Materials and Website Policy, entire document<br><br>**The following flyers are used to inform members of EPSDT benefits by mail, and are available in English and Spanish.**<br>• XI.EPSDT.2_EPSDT Well Child Flyer - ENG<br>• XI.EPSDT.2_EPSDT Well Child Flyer -SP<br>• XI.EPSDT.2_EPSDT School Physicals Flyer - ENG<br>• XI.EPSDT.2_EPSDT School Physicals Flyer_SP<br>• XI.EPSDT.2_EPSDT_Flu_Flyer_ENG<br>• XI.EPSDT.2_EPSDT_Flu_Flyer_SP<br>• XI.EPSDT.2_EPSDT_Dental_Flyer - ENG | |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • XI.EPSDT.2_EPSDT_Dental_Flyer_SP<br><br>**The following document lists the pages on the CCHA website that include EPSDT benefit information for members.**<br>• XI.EPSDT.2_Standard Member URLs, entire document<br><br>**The following document lists the CCHA webpage that includes EPSDT benefit information for providers.**<br>• XI.EPSDT.2_Standard Provider URLs, entire document<br><br>**The following CCHA Provider Newsletter includes an article with information about EPSDT benefits and services.**<br>• XI.EPSDT.2_EPSDT Specialist Newsletter_January 2024, pg. 4<br><br>**The following document includes scripted messages used to outreach members via automated phone call and text messaging.**<br>• XI.EPSDT.1_R6_EPSDT Strategy Plan, pgs. 5-6 | |
| 3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by:<br>• Using Department materials to inform network providers about the benefits of well-child care and EPSDT. | **CCHA's Behavioral Health Provider Manual includes information on EPSDT benefits and informs providers of training materials available through HCPF.** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Ensuring that trainings and updates on EPSDT are made available to network providers every six months.<br><br>Contract Amendment 17: Exhibit B—12.9.2.1, 12.9.3 | • XI.EPSDT.3_BH Provider Manual, pgs. 34-35<br><br>**CCHA's Physical Health Provider Manual includes information on EPSDT benefits and informs providers of training materials available through HCPF.**<br>• XI.EPSDT.3_PH Provider Manual, pgs. 31-33<br><br>**The following CCHA Provider Newsletter informed providers of the EPSDT benefit and linked to HCPF resources for EPSDT educational materials.**<br>• XI.EPSDT.3_EPSDT BH Provider Bulletin_September, pg. 9<br><br>**The April 2024 edition of the CCHA Provider Newsletter informed providers that CCHA produced an EPSDT recorded webinar and provided the link to view this educational resource on its website.**<br>• XI.EPSDT.2_EPSDT Provider Newsletter_April, pg. 1<br>• XI.EPSDT.2_Provider URLs<br><br>**The following Special Bulletin email informed community partners of EPSDT benefits and how CCHA can help support members, provided links to HCPF resource materials, and shared the link to CCHA's recorded EPSDT educational webinar.** | |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • XI.EPSDT.3_EPSDT Special Bulletin_Sept 2024, entire document | |
| 4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program).<br><br>For the *Capitated Behavioral Health Benefit*, the RAE:<br>• Has written policies and procedures for providing EPSDT services to members ages 20 and under.<br>• Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it.<br>• Ensures screenings are performed by a provider qualified to furnish mental health services.<br>• Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner.<br>• Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed, and the date ordered.<br>• Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. | **The following document outlines CCHA's policy and procedure related to EPSDT, which includes the provision of all medically necessary behavioral health services for children under age 21 in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280.**<br>• XI.EPSDT.1_EPSDT Policy, pg. 5<br><br>**The following care coordination program descriptions outline care coordination activities for pediatric, foster care, and maternity populations, including that care coordinators will assist in arranging for the provision of all medically necessary services, and supports the member in accessing appropriate health screenings through qualified providers and in a manner that is culturally and linguistically sensitive to the member.**<br>• XI.EPSDT.1_CCHA Program Description – Pediatrics, pgs. 6<br>• XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 7-8<br><br>**The following document outlines CCHA's policy regarding the provision of medically necessary services through using clinical criteria for utilization management decisions.** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *42 CFR 441.55; 441.56(c)*<br><br>Contract Amendment 17: Exhibit B—14.5.3<br>10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3) | • XI.EPSDT.4_BH UM Manual-EPSDT Workflow, entire | |
| 5. *For the Capitated Behavioral Health Benefit,* the RAE:<br>• Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis.<br>• Provides assistance with transportation and scheduling appointments for services if requested by the member/family.<br>• Makes use of appropriate State health agencies and programs including vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program.<br><br>*42 CFR 441.61–62*<br><br>Contract Amendment 17: Exhibit B—14.5.3<br>10 CCR 2505-10 8.280.4.C | **The following assessment is completed by CCHA and identifies member needs and referrals, including educational/vocational, transportation, family/caregiver, and social services such as WIC, SNAP, TANF, Prenatal Plus, etc.**<br>• XI.EPSDT.5_Member Benefit Assessment, entire<br>• XI.EPSDT.5_Peds HNA, entire<br><br>**CCHA's Behavioral Health Provider Manual outlines that CCHA provides referral assistance, assistance with transportation, and makes use of other state health agencies and programs.**<br>• XI.EPSDT.3_BH Provider Manual, pg. 35<br><br>**CCHA's Physical Health Provider Manual outlines that CCHA provides referral assistance, assistance with transportation and makes use of other state health agencies and programs.**<br>• XI.EPSDT.3_PH Provider Manual, pgs. 31-33<br><br>**The following document serves as a CCHA member guide for Health First Colorado members and is available in English and Spanish. It includes information on how to contact CCHA, that CCHA** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **can help with scheduling appointments, arranging transportation, and connecting members to other resources.**<br>• XI.EPSDT.5_Map to Medicaid – English, entire<br>• XI.EPSDT.5_Map to Medicaid – Spanish, entire<br><br>**The following flyers are used to inform members of EPSDT benefits by mail and are available in English and Spanish.**<br>• XI.EPSDT.2_EPSDT Well Child Flyer - ENG<br>• XI.EPSDT.2_EPSDT Well Child Flyer -SP<br>• XI.EPSDT.2_EPSDT School Physicals Flyer - ENG<br>• XI.EPSDT.2_EPSDT School Physicals Flyer_SP<br>• XI.EPSDT.2_EPSDT_Flu_Flyer_ENG<br>• XI.EPSDT.2_EPSDT_Flu_Flyer_SP<br>• XI.EPSDT.2_EPSDT_Dental_Flyer - ENG<br>• XI.EPSDT.2_EPSDT_Dental_Flyer_SP<br><br>**The following document serves as a quick reference guide to behavioral health and is available in English and Spanish. It includes information on how to contact CCHA and that CCHA can help with connecting members to needed resources, including transportation.**<br>• XI.EPSDT.5_BH Reference Guide - English<br>• XI.EPSDT.5_BH Reference Guide – Spanish | |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **The following care coordination program descriptions outline care coordination activities for pediatric, foster care, and maternity populations, including that CCHA provides referral and transportation assistance as needed.**<br>• XI.EPSDT.1_CCHA Program Description - Pediatrics, pg. 6<br>• XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 7-8 | |
| 6. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that:<br>• Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.<br>• Assists the member to achieve or maintain maximum functional capacity.<br>• Is provided in accordance with generally accepted professional standards for health care in the United States.<br>• Is clinically appropriate in terms of type, frequency, extent, site, and duration. | **The following document outlines CCHA's policy related to evaluating clinical criteria for utilization management decisions and includes the definition of medical necessity for EPSDT services.**<br>• XI.EPSDT.4_BH UM Manual-EPSDT Workflow, entire<br><br>**CCHA's Behavioral Health Provider Manual outlines the definition of medical necessity as it pertains to EPSDT benefits and services.**<br>• XI.EPSDT.3_BH Provider Manual, pgs. 35<br><br>**CCHA's Physical Health Provider Manual outlines the definition of medical necessity as it pertains to EPSDT benefits and services.**<br>• XI.EPSDT.3_PH Provider Manual, pgs. 31-33 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Is not primarily for the economic benefit of the provider nor primarily for the convenience of the client, caretaker, or provider.<br>• Is delivered in the most appropriate setting(s) required by the client's condition.<br>• Provides a safe environment or situation for the child.<br>• Is not experimental or investigational.<br>• Is not more costly than other equally effective treatment options.<br><br>Contract Amendment 17: Exhibit B—14.5.3<br>10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E | | |
| 7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services.<br><br>*Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).*<br><br>Contract Amendment 17: Exhibit B—14.5.7.1 | **The following document outlines CCHA's policy and procedure related to EPSDT, which includes the arrangement for the provision of all medically necessary behavioral health services for diagnoses listed in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses for children under the age of 21 in accordance with Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 and 1915(b)(3) Waiver services to members in at least the scope, amount and duration proposed in the Uniform Service Coding Standards (USCS) Manual. All 1915(b)(3) services provided to children/youth from age 0 to 21, except for respite and vocational rehabilitation, are included in the** | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **State Plan as EPSDT services.**<br>• XI.EPSDT.1_EPSDT Policy, pg. 7<br><br>**The following care coordination program descriptions outline care coordination activities for pediatric, foster care, and maternity populations, including that CCHA provides or arranges for vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, and respite services.**<br>• XI.EPSDT.1_CCHA Program Description – Pediatrics, pg. 6<br>• XI.EPSDT.1_CCHA Program Description - Maternity, pgs. 7-8<br><br>**The following assessment is completed by CCHA to identify member needs, including vocational services, and outlines referrals to behavioral health services.**<br>• XI.EPSDT.5_Member Benefit Assessment<br>• XI.EPSDT.5_Peds HNA<br><br>**CCHA informs behavioral health providers of this requirement via the Provider Manual.**<br>• XI.EPSDT.3_BH Provider Manual, pg. 35 | |

| Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | **The following MOU outlines CCHA's collaboration with the Department of Human Services in El Paso County, which includes roles and responsibilities, referral processes and identified a single point of contact for members who may be utilizing services that are covered under the Capitated Behavioral Health Benefit.**<br>• XI.EPSDT.7_El Paso MOU<br>• XI.EPSDT.7_El Paso MOU AMD<br>• XI.EPSDT.7_El Paso JI CMP MOU<br><br>**The following document demonstrated the coordination of EPSDT services in a Creative solution call by a CCHA care coordinator.**<br>• XI.EPSDT.7_Creative Solution note R6 | |

| Results for Standard XI—EPSDT Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 7 | X | 1.00 | = | 7 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 7 | **Total Score** | | = | 7 |
| | | | | | | | |
| | | | | **Total Score ÷ Total Applicable** | | = | 100% |

# Appendix B. Colorado Department of Health Care Policy & Financing
# FY 2024–2025 External Quality Review
# Initial Credentialing Record Review
# for Colorado Community Health Alliance RAE 6

| | |
|---|---|
| **Review Period:** | January 1, 2024 – December 31, 2024 |
| **Completed By:** | Heather Pickell |
| **Date of Review:** | February 11, 2025 – February 12, 2025 |
| **Reviewer:** | Crystal Brown |
| **Participating MCE Staff Member During Review:** | Todd Hong and Heather Pickell |

| Requirement | File 1 | File 2 | File 3 | File 4 | File 5 | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Provider ID #** | ***** | ***** | ***** | ***** | ***** | ***** | ***** | ***** | ***** | ***** |
| **Provider Type** (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD) | LPC | NP | LADC | LPC | LPC | LPC | MD | LPC | CSW | CSW |
| **Provider Specialty** (e.g., PCP, surgeon, therapist, periodontist) | Professional Counselor | Nurse Practitioner | Addiction Counselor | Professional Counselor | Professional Counselor | Professional Counselor | Psychiatry | Professional Counselor | Social Worker | Social Worker |
| **Date of Completed Application** [MM/DD/YYYY] | 1/31/2024 | 3/8/2024 | 3/19/2024 | 5/13/2024 | 6/27/2024 | 8/20/2024 | 8/1/2024 | 9/18/2024 | 10/29/2024 | 11/26/2024 |
| **Date of Initial Credentialing** [MM/DD/YYYY] | 2/1/2024 | 3/14/2024 | 4/8/2024 | 5/20/2024 | 7/3/2024 | 8/27/2024 | 9/21/2024 | 10/1/2024 | 11/15/2024 | 12/3/2024 |
| **Completed Application for Appointment Met? [VIII.8]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Verification of Current and Valid License** Yes, No, Not Applicable (NA) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Verification of Current and Valid License Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Board Certification** Yes, No, NA | NA | Yes | NA | NA | NA | NA | NA | NA | NA | NA |
| **Evidence of Board Certification Met? [VIII.6]** | NA | Met | NA | NA | NA | NA | NA | NA | NA | NA |
| **Evidence of Valid DEA or CDS Certificate** (for prescribing providers only) Yes, No, NA | NA | Yes | NA | NA | NA | NA | Yes | NA | NA | NA |
| **Evidence of Valid DEA or CDS Certificate Met? [VIII.6]** | NA | Met | NA | NA | NA | NA | Met | NA | NA | NA |
| **Evidence of Education/Training Verification** Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Education/Training Verification Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Work History** (most recent five years or, if less, from the time of initial licensure) Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Work History Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Malpractice History** Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Malpractice History Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence Malpractice Insurance/Required Amount** (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Verification That Provider Is Not Excluded From Federal Participation** Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Comments:** **N/A** | | | | | | | | | | |

# Appendix B. Colorado Department of Health Care Policy & Financing
# FY 2024–2025 External Quality Review
# Initial Credentialing Record Review
# for Colorado Community Health Alliance RAE 6

| Scoring | File 1 | File 2 | File 3 | File 4 | File 5 | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Applicable Elements | 7 | 9 | 7 | 7 | 7 | 7 | 8 | 7 | 7 | 7 |
| Compliant (Met) Elements | 7 | 9 | 7 | 7 | 7 | 7 | 8 | 7 | 7 | 7 |
| Percent Compliant | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Total Applicable Elements | 73 | | | | | | | | | |
| Total Compliant Elements | 73 | | | | | | | | | |
| Total Percent Compliant | 100% | | | | | | | | | |

**Notes:**

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

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

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

**365 Calendar Days**
- Signed application/attestation
- Work history

## Appendix B. Colorado Department of Health Care Policy & Financing
## FY 2024–2025 External Quality Review
## Recredentialing Record Review
## for Colorado Community Health Alliance RAE 6

| | |
|---|---|
| **Review Period:** | January 1, 2024 – December 31, 2024 |
| **Completed By:** | Heather Pickell |
| **Date of Review:** | February 11, 2025 – February 12, 2025 |
| **Reviewer:** | Crystal Brown |
| **Participating MCE Staff Member During Review:** | Todd Hong and Heather Pickell |

| Requirement | File 1 | File 2 | File 3 | File 4 | File 5 | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Provider ID #** | ***** | ***** | ***** | ***** | ***** | ***** | ***** | ***** | ***** | ***** |
| **Provider Type** (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD) | MFT | PhD | LPC | LPC | CSW | PSY | CSW | LPC | LPC | MD |
| **Provider Specialty** (e.g., PCP, surgeon, therapist, periodontist) | Marriage & Family Therapy | Psychology, Clinical | Professional Counselor | Professional Counselor | Social Worker | Psychology, Clinical | Social Worker | Professional Counselor | Professional Counselor | Psychiatry |
| **Date of Last Credentialing** [MM/DD/YYYY] | 6/22/2021 | 7/28/2021 | 8/31/2021 | 9/27/2021 | 10/15/2021 | 11/12/2021 | 7/7/2022 | 1/20/2022 | 02/16/2022 | 2/9/2022 |
| **Date of Recredentialing** [MM/DD/YYYY] | 1/31/2024 | 2/28/2024 | 4/3/2024 | 5/13/2024 | 5/29/2024 | 6/26/2024 | 7/31/2024 | 8/20/2024 | 09/20/2024 | 9/26/2024 |
| **Months From Initial Credentialing to Recredentialing** | 31 | 31 | 31 | 31 | 31 | 31 | 24 | 31 | 31 | 31 |
| **Time Frame for Recredentialing Met? [VIII.9]** Is completed at least every three years (36 months) | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Verification of Current and Valid License** Yes, No, Not Applicable (NA) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Verification of Current and Valid License Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Board Certification** Yes, No, NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | Yes |
| **Evidence of Board Certification Met? [VIII.6]** | NA | NA | NA | NA | NA | NA | NA | NA | NA | Met |
| **Evidence of Valid DEA or CDS Certificate** (for prescribing providers only) Yes, No, NA | NA | NA | NA | NA | NA | NA | NA | NA | NA | Yes |
| **Evidence of Valid DEA or CDS Certificate Met? [VIII.6]** | NA | NA | NA | NA | NA | NA | NA | NA | NA | Met |
| **Evidence of Malpractice History** Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Malpractice History Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Malpractice Insurance/Required Amount** (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation** Yes, No, NA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]** | Met | Met | Met | Met | Met | Met | Met | Met | Met | Met |
| **Comments:** **N/A** | | | | | | | | | | |

# Appendix B. Colorado Department of Health Care Policy & Financing
# FY 2024–2025 External Quality Review
# Recredentialing Record Review
# for Colorado Community Health Alliance RAE 6

| Scoring | File 1 | File 2 | File 3 | File 4 | File 5 | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Applicable Elements | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 7 |
| Total Compliant (Met) Elements | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 7 |
| Total Percent Compliant | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Total Applicable Elements** | **52** | | | | | | | | | |
| **Total Compliant Elements** | **52** | | | | | | | | | |
| **Total Percent Compliant** | **100%** | | | | | | | | | |

**Notes:**

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

   **Prior to Credentialing Decision**
   - DEA or CDS certificate

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

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

# Appendix C. Compliance Review Participants

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

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

| HSAG Reviewers | Title |
|---|---|
| Gina Stepuncik | Associate Director |
| Sara Dixon | Project Manager III |
| Crystal Brown | Project Manager I |
| **CCHA Participants** | **Title** |
| Cara Hebert | Director, Account Management and External Partnerships, Region 6 Program Officer |
| Krista Newton | Director, Care Coordination |
| Tony Olimpio | Manager, Member Support Services |
| Michelle Blady | Manager, Behavioral Health Services and Utilization Management Director, Region 7 |
| Amy Yutzy | Elevance Health Behavioral Health Market Lead and Region 7 Program Officer |
| Megan Billesbach | Community Health Strategist |
| Jen Bustillos | Supervisor, Care Coordination |
| Christie Cimermancic | Lead, Outreach Care Specialist |
| Katie DeFord | Quality Program Manager |
| Melissa Fisk | Behavioral Health Lead, Region 6 |
| Aimee Goodbar | Utilization Management Lead |
| Andrea Kedley | Supervisor, Community Health Strategist |
| Emily Kimmich | Supervisor, Care Coordination |
| Marianne Lynn | Manager, Compliance |
| Kathryn Morrison | Director, Quality Improvement |
| Erica Nissen | Clinical Program Manager |
| Abigail Roa Justiniano | Director, Compliance |
| Andrea Skubal | Contract Manager |
| Kathryn Stingl | Behavioral Health Lead, Region 7 |
| Sarah Winfrey | Supervisor, Care Coordination |
| Todd Hong | Manager, Credentialing |

| CCHA Participants | Title |
|---|---|
| Heather Pickell | Credentialing Specialist |
| Caitlyn Marshall | Compliance Consultant, Delegation Oversight |
| Rebekah Hensley-Martin | Manager, Delegation Oversight |
| **Department Observers** | **Title** |
| Russell Kennedy | Quality and Compliance Specialist |
| Tom Franchi | Accountable Care Collaborative Program Specialist |
| Lexis Mitchell | Program Specialist, Regions 6 and 7 |

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

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

**Table D-1—CAP Process**

| Step | Action |
|---|---|
| **Step 1** | **CAPs are submitted** |
| If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE must submit the CAP using the template provided.<br><br>For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions. | |
| **Step 2** | **Prior approval for timelines exceeding 30 days** |
| If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing. | |
| **Step 3** | **Department approval** |
| Following review of the CAP, the Department and HSAG will:<br>• Review and approve the planned interventions and instruct the MCE to proceed with implementation, or<br>• 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 to proceed with resubmission. | |
| **Step 4** | **CAPs are closed** |
| Once the MCE has received Department approval of the CAP, the MCE will be instructed that it may proceed with the planned interventions and the CAP will be closed. RAE Accountable Care Collaborative 2.0 contracts end June 30, 2025. RAEs that continue to contract with the Department are encouraged to follow through on completion of their CAP(s) to ensure compliance with their new contract. | |

The CAP template follows on the next page.

**Table D-2—FY 2024–2025 CAP for CCHA**

| Standard VIII—Credentialing and Recredentialing |
|---|
| ☐ Plan(s) of Action Complete<br>☐ Plan(s) of Action on Track for Completion<br>☐ Plan(s) of Action Not on Track for Completion |
| **Requirement** |
| 2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify:<br>2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor.<br>The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers.<br>*Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*<br>*42 CFR 438.214(a)–(b)(1)*<br>NCQA CR1—Element A1<br>Contract Amendment 17: Exhibit B—9.1.6 |
| **Findings** |
| CCHA submitted evidence of a credentialing policy posted to its website that was timestamped on the website as being updated on the day of the compliance review. That policy, however, did not meet the requirement for including information on how CCHA conducts provider retention. |
| **Required Actions** |
| CCHA must incorporate a section in its current credentialing policy or develop a standalone policy for how CCHA retains providers and make the policy available on its public website. |

| Standard VIII—Credentialing and Recredentialing—For Both RAEs |
|---|
| **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:** |
| **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 E. Compliance Monitoring Review Protocol Activities

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

**Table E-1—Compliance Monitoring Review Activities Performed**

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

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