COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2019–2020 Site Review Report

for

Health Colorado, Inc.

Region 4

May 2020

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2019–2020 site review activities for **Health Colorado, Inc. (HCI**). For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2019–2020 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol. Appendix F includes the summary of the focus topic interviews with RAE staff members used to gather information for assessment of statewide trends related to the FY 2019–2020 focus topic selected by the Department.

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	30	29	1	0	4	97%
II. Access and Availability	16	16	15	1	0	0	94%
VI. Grievances and Appeals	35	35	29	6	0	0	83%
Totals	**85**	**81**	**73**	**8**	**0**	**4**	**90%**

*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.

Table 1-2 presents the scores for **HCI** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are 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)
Denials	90	60	52	8	30	87%
Grievances	60	51	49	2	9	96%
Appeals	24	23	19	4	1	83%
Totals	**174**	**134**	**120**	**14**	**40**	**90%**

*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.

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

HCI submitted a large body of evidence to substantiate compliance with coverage and authorization of services requirements. **HCI** delegated utilization management (UM) functions for all behavioral health services to Beacon Health Options (Beacon). **HCI**'s submission included policies, procedures, reports, work plans, tools, manuals, and sample denial and extension letters. HSAG reviewed all submissions and found that documents illustrated a thorough and comprehensive approach for review, authorization, and denial of RAE-covered services.

During on-site denial record reviews, HSAG observed that the notice of adverse benefit determination (NOABD) demonstrated the required content, including the reason for the decision, the member's right to appeal and to request a State review, and the possibility of requesting continued service/benefits pending the resolution of the appeal. Authorization requests could be submitted by phone, fax, or through **HCI**'s "Connect" system. Regardless of the method of submission, all authorization requests were documented in the Connect system—**HCI**'s proprietary integrated data and information system. **HCI** staff members demonstrated the Connect system during the on-site audit, and HSAG observed documentation of all required processes related to initial and continuing authorization of services.

HCI's *Medically Necessary Determinations, Lack of Information Timelines* policy outlined the required time frames for making standard and expedited authorization decisions and information required to do so. **HCI**'s sample denial records were standard authorization requests that illustrated compliance with decisions being made within 10 calendar days following the receipt of the request for service. HSAG observed time stamps on the requests and decisions completed.

HCI explained that requests for authorization can be approved at different levels based on staff credentials. **HCI** staff members apply InterQual criteria to medical records and clinical criteria. **HCI**'s clinical care managers (CCMs) are typically licensed Master's level professional counselors or certified social workers. CCMs can authorize services within a predetermined scope of care—e.g., outpatient care, acute treatment units, partial hospitalization program, and some inpatient services. All requests for services outside of the CCM's scope of authorization—intensive outpatient treatment services, residential treatment, retroactive authorizations, single case agreements, and/or complex mental health conditions (e.g., eating disorders)—must be reviewed by one of **HCI**'s medical directors with specialization in Psychiatry. CCMs do not have the authority to deny any request for authorization; all adverse benefit determinations are reviewed and denied at the medical director level. **HCI**'s staff members described the close working relationships and open communication with its contracted providers, facilities, community mental health centers (CMHCs), and community stakeholders. **HCI** credits these strong relationships with the RAE's ability to obtain the clinical information necessary to render a timely decision (i.e., less than 10 days) and identify community resources to ensure smooth member transitions to a lower level of care.

Summary of Findings Resulting in Opportunities for Improvement

Regarding authorization requests processed during business hours, **HCI** referred HSAG to the notes in the Connect system that documented the "time of receipt" of an authorization request and "time of decision." Due to the possibility that entering staff notes in the system may not always be real-time, HSAG cautions that consistent documentation of time stamps would be necessary to ensure compliance with time frames applicable to expedited authorization requests. HSAG recommends that **HCI** implement a process to use the time stamp in the Connect system to accurately document receipt of requests and decisions made on authorization requests.

Summary of Required Actions

HCI demonstrated that the NOABD included all required content and was available in prevalent non-English languages and alternative formats for persons with special needs. However, HSAG found eight of 10 denial record reviews were *Not Met* for "correspondence with the member was easy to understand." **HCI**'s reason for the adverse benefit determination incorporated language such as "exclusionary criteria," "emphasis," and "less restrictive" in describing the reason for the denial, which would be difficult for Medicaid members with limited reading ability to understand. **HCI** must ensure that the NOABD in its entirety is written in language that is easy for a member to understand.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

HCI delegated the functions of maintaining, evaluating, and monitoring the provider network to Beacon. **HCI**'s document submission included policies, procedures, GeoAccess reporting, work plans, committee meeting minutes, provider education/training, provider directory, and sample provider single case agreement letters. HSAG reviewed all submissions and found that documents demonstrated compliance with access and availability requirements.

HCI's *Provision of Service Through an Out of Network Provider* policy illustrated the process and procedures for implementation and use of single case agreements (SCAs). Since opening the RAE network to all providers interested in contracting, the instances of SCAs have decreased. Staff members reported that most SCAs apply to providers that are engaged in the process of credentialing. The SCA allows for no disruptions in the continuity of care while the contracting process is being finalized. SCAs are also used for providers that can offer care in a specific language or render care/treatment of a specific condition such as eating disorders. **HCI** generated a monthly internal report to monitor SCAs issued by the RAE. **HCI** used the report to identify opportunities to pursue and establish new provider network contracts. The RAE also compared the attribution report received from the State to its existing provider network to identify providers that are not contracted. The RAE described actions taken by the Provider

Relations Department to initiate contracting discussions with these providers. **HCI** provided these examples as mechanisms used by **HCI** to establish, monitor, and maintain its provider network.

During on-site interviews, **HCI** described its efforts to promote the delivery of services in a culturally competent manner. The RAE's rural and frontier geographic service areas include many different cultures that **HCI** takes into consideration when anticipating and meeting the healthcare needs of its members. **HCI**'s community care coordinators engage members in their homes, support them at behavioral and physical health appointments, and partner with community stakeholders. **HCI** provided an example of an outreach and education initiative specific to the unique needs and challenges that impact the mental health of the farming, migrant worker, and agricultural communities within the region. Due to concerns regarding the increase in the number of suicides among this population, the RAE partnered with its CMHC in the area to develop a multi-dimensional initiative that included educating the community about the importance of mental health; ensuring that providers were trained and qualified to offer support and guidance to address the stress experienced by community members; and making resources, materials, and hotlines available to the community. The RAE and CMHC leveraged the support of farming supply companies and other community businesses to distribute education and messaging regarding available resources. **HCI** also deployed mobile health vehicles to provide care to farmers and migrant workers.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HCI submitted its provider manual, Access to Care Standards Training Webinar, and BH Access to Care webpage to demonstrate its efforts to educate the provider network on the required appointment standards for timely access to care and services. **HCI** implemented a phone survey of a small sample of the behavioral health network to evaluate the availability and timeliness of scheduling appointments for RAE members. Survey results illustrated that all of the standards were met by four of the 12 providers surveyed; four providers did not have appointment availability for new members; and four providers were nonresponsive to **HCI**'s outreach attempts. **HCI** must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). **HCI** must also ensure implementation of corrective action plans for providers that are not in compliance with these access to care standards.

Standard VI—Grievances and Appeals

Summary of Strengths and Findings as Evidence of Compliance

HCI delegates processing of appeals and grievances to its partner organization, Beacon. Beacon delegates processing of grievances applicable to its own members to five federally qualified health center (FQHC) and CMHC entities. The *Complaint Delegation and Procedures* agreement thoroughly outlines grievance procedures and expectations of the delegates with oversight by Beacon. Beacon maintained comprehensive grievance and appeal policies and procedures and member template communication documents addressing all grievance and appeal requirements, including: accurate definitions of "adverse benefit determination," "appeal," and "grievance"; accepting verbal or written grievances and appeals; maintaining a designated client representative (DCR) process; provision of assistance to members in preparing grievances and appeals; consideration of all information submitted by the member or DCR when processing grievances or appeals; accurate time frames for proving notices to members with required content; and ensuring appropriate reviewers for making decisions on grievances and appeals. During on-site interviews, staff members demonstrated thorough understanding of all grievance and appeal requirements. On-site grievance record reviews demonstrated 96- percent compliance overall with all applicable requirements. On-site appeal record reviews demonstrated 83 percent compliance overall, which included 100 percent compliance in five of the six appeal requirements. Beacon maintained local medical reviewers and a panel of corporate peer advisors with clinical expertise to make denial and appeal decisions, enabling decisions to be made by appropriate reviewers and to be made within all required time frames. Beacon time- and date-stamped all appeal requests and notices of resolution to enable expedited decisions to be made with 72 hours. Member notices of grievance and appeal resolution were written in easy-to-understand language, including taglines and offering alternative formats for members with special needs. Notices to members included all required information. Beacon maintained a grievance database for tracking grievance processes that collected all required information from both delegates and **HCI** staff members concerning grievances throughout the region. Beacon maintained an appeal database meeting all appeal data requirements and enabling reporting to the Department. The **HCI** provider handbook thoroughly outlined the member grievance and appeal processes.

Summary of Findings Resulting in Opportunities for Improvement

The information in the appeal resolution letter related to continuing benefits during a State fair hearing (SFH) did not clarify that the member must be the one to request continued benefits (i.e., not the provider) and did not explain that a request for continued benefits during an SFH applies only if the member had also continued benefits during the appeal. HSAG recommends enhancing the appeal resolution letter to address such information.

HSAG noted that the provider handbook did not indicate *how* a member must request continued benefits (e.g., from Health Colorado) nor did it specify that a provider cannot request continued benefits on

behalf of a member. HSAG recommends that **HCI** consider adding these clarifications to the provider handbook.

During on-site appeal record reviews, 10 of 15 records were omitted from the sample as "appeals not processed" due to provider procedural issues—e.g., appeal filed outside required time frame, no member DCR form, or original denial was for no authorization obtained by the provider. HSAG noted that claims not paid (and related appeals) due to reasons of procedural issues on the provider's part are not member appeals and should be processed through **HCI**'s provider dispute process. To that end, HSAG strongly recommends that **HCI** enhance internal procedures to:

- Ensure provider appeals of unpaid claims (if due to provider procedural issues) are not recorded in the member appeal database and are internally redirected to staff members responsible for processing provider disputes. Members should not be informed of provider procedural or payment issues, as these are not member appeals and do not concern the member.
- Ensure **HCI** informs the requesting provider that provider payment appeals received through the member appeal process are not member appeals and the provider may alternatively use the provider dispute process.
- Ensure that **HCI** does not inadvertently deny a provider his or her right to consideration through the provider dispute process.
- Enhance provider training and communications to emphasize that the provider dispute process is the mechanism through which provider procedural issues and payment disputes may be considered.

HSAG noted that, when an appeal is requested by the member's DCR, the appeal resolution letter is directed to the DCR—often a provider—and copied to the member. Whereas regulations require notice to the member, **HCI** may want to consider directing the letter to the member and copying the DCR/provider. In addition, HSAG observed that the appeal resolution letter includes language explaining "What this means to the provider" followed by "What this means to the member." Since this is a member appeal, the member does not need to be concerned with what this means to the provider. The letter also includes extensive information on how the appeal decision was made. HSAG recommends that **HCI** consider simplifying the content of the appeal resolution letter to more overtly state the appeal decision and, if the appeal decision upholds the original denial, consistently communicate that the member cannot be billed by the provider for unpaid services.

The **HCI** provider handbook described a peer-to-peer reconsideration process "after denial of authorization." During on-site interviews, staff members clarified that the NOABD is pended for 24 hours to allow for the peer-to-peer reconsideration. HSAG cautions that **HCI** ensure the peer-to-peer reconsideration is consistently applied prior to issuing the NOABD; otherwise, this process constitutes a second level of appeal.

Complaint Delegation and Procedures requires that delegated entities enter grievance information in the **HCI** grievance ("feedback") database within one week following the end of each month. Staff members explained that **HCI** monitors the appropriate processing of grievances through the feedback database. HSAG encourages **HCI** to consider requiring delegates to more frequently enter documentation of

grievances in the grievance database to enable more timely monitoring of delegates' grievance processing and trends.

Summary of Required Actions

While the *Grievance Policy*, *Complaint Delegation and Procedures*, and template complaint resolution letter accurately addressed the required content of grievance resolution notices, HSAG noted one case in on-site record reviews in which the results of the grievance resolution in the complaint resolution letter did not address the member's stated complaint. **HCI** must develop a mechanism to ensure that the description of the grievance resolution in grievance resolution letters thoroughly addresses a member's stated complaint.

While **HCI**'s *Appeal Policy* and member communications regarding appeal processes accurately defined the 120-day time frame for requesting an SFH, the *SFH Guide* also inaccurately stated that "If Health Colorado does not follow the appeal time frames, you may request an SFH *before you file an appeal*." The member must file an appeal with Health Colorado before requesting an SFH. **HCI** must correct its *SFH Guide* to remove the phrase "before you file an appeal" from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames.

While internal policies and procedures accurately defined the content of the appeal resolution letter, the content of actual appeal resolution letters and the *SFH Guide* insert included several inaccuracies related to procedures and circumstances for requesting continued benefits during an SFH. As further described in the findings of Standard VI, elements #26 and #29 in the Compliance Monitoring Tool incorporated in this report, inaccuracies included:

- Neither the appeal resolution letter nor the *SFH Guide* explained *how* the member may request continued benefits during an SFH—i.e., through Health Colorado within 10 days of receiving an adverse appeal resolution notice.
- The *SFH Guide* stated that the criteria for continuing benefits during an SFH included "the time period for the authorized services must not yet be over" (applies to continued benefits during appeals but not SFH).
- The *SFH Guide* stated that the criteria for continuing benefits during an SFH included "the member must request an SFH within 10 days."
- The *SFH Guide* included the description, "you do not request an SFH and continued services within 10 days of an appeal decision not in your favor" as a criterion for how long benefits will continue during an SFH (applies to continued benefits during appeals but not an SFH).

HCI must revise its appeal resolution letter and *SFH Guide* to accurately describe the procedures and circumstances for requesting continued benefits during an SFH.

HCI's provider handbook included inaccuracies in the circumstances and standards related to requesting continued benefits during an SFH (as described above). **HCI** must revise the grievance and appeal

information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH.

HCI's sample letter of an overturned appeal decision informed the member that he or she may request an SFH. A request for an SFH applies only to "appeals not resolved in favor of the member." **HCI** must remove information regarding the member's right to request an SFH from its overturned appeal decision letters.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three standards. In addition, the Department requested that HSAG conduct on-site group interviews with key RAE staff members to explore individual RAE experiences related to one focus topic. The focus topic chosen by the Department for 2019–2020 was *Region-specific Initiatives Related to the Health Neighborhood.*

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable.* The Department determined that the review period was January 1, 2019, through December 31, 2019. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to each of denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to RAE denials of authorization, grievances, and appeals to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial records, all grievance records, and all appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

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

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (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 **HCI** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Related to coordination and continuity of care, **HCI** was required to complete two corrective actions:

- Enhance provider communications to require that each provider furnishing services to the member shares, as appropriate, the member health record with other providers or organizations involved in the member's care.
- Ensure that the electronic care coordination tool used by each accountable care coordination entity includes the minimum required elements outlined in the RAE contract.

Related to EPSDT services, **HCI** was required to complete the process of developing and executing an onboarding plan with each Healthy Communities contractor in the region.

Summary of Corrective Action/Document Review

HCI submitted a proposed CAP in June 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **HCI**. **HCI** submitted initial documents as evidence of completion in October 2019. Following review by HSAG and the Department, **HCI** was required to resubmit additional documentation as evidence of completion in December 2019 and February 2019. HSAG and the Department found all required actions were successfully completed in March 2019.

Summary of Continued Required Actions

HCI successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-2—14.6.2	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. **Evidence used:** 1. HCI Administrative Services Agreement, pages 14-16 2. 202L--Medical Necessity Determinations, entire policy 3. Health First Colorado Member Handbook, pages 18-24 *Misc. **Narrative:** All utilization management (UM) functions for the capitated behavioral health benefit of Health Colorado's Medicaid contract are delegated to Beacon Health Options as the administrative services organization for HCI (see HCI Administrative Services Agreement**).** As UM functions are delegated to Beacon, its policies and procedures showcase HCIs' adherence to State and Federal requirements for the coverage and authorization of services; thus, Beacon's policies and procedures are referenced throughout this compliance-monitoring tool. The amount, duration, and scope of services is limited only by the determination of medical necessity (see Section II.C of 202L--Medical Necessity Determinations). Services that are determined to be medically necessary are not otherwise limited. For example, there are no episode	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of care, annual, or lifetime benefit limits. Services under this health plan are not less than the amount, duration, and scope of services that are available under fee-for-service Medicaid. A description of the covered services can be found in the Health First Colorado Member Handbook as well (see pages 18-24).	
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-2—14.6.4	**Evidence used:** 1. 202L-- Medical Necessity Determinations, section II, D 2. Exhibit I-Capitated BH Benefit Covered Services and Diagnoses, entire document 3. 303L--Peer Advisor Adverse Determinations, entire policy 4. Level of Care-Medical Necessity Guidelines, see Level of Care-Medical Necessity Guidelines folder **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's UM staff refer to the medical necessity policy (see 202L Medical Necessity Determinations), the list of covered diagnoses (see Exhibit I-Covered Behavioral Health Services and Diagnoses), and the clinical level of care criteria to authorize care to help ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Only the Medical Director or the Clinical Peer Advisor (see 303 L--Peer Advisor Adverse Determinations) can deny care.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Variables such as the member's situation and other care available are considered in each individual situation. UM staff work with providers to review the member's care and give input into discharge planning to help members achieve long-term stabilization and sustained improvement. Beacon's UM staff refer cases for possible adverse clinical decisions to the Medical Director/Peer Advisor for review (see 303L--Peer Advisor Adverse Determinations).	
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. *42 CFR 438.210(a)(4)* Contract: Exhibit B-2—14.6.5, 14.6.5.1–2	**Evidence used:** 1. 202L--Medical Necessity Determinations, section I, Section 11.E 2. Exhibit I-Capitated BH Benefit Covered Services and Diagnoses, entire document 3. Level of Care-Medical Necessity Guidelines, see Level of Care-Medical Necessity Guidelines folder **Narrative:** This required element is delegated to Beacon Health Options by HCI. The Medical Necessity Determinations policy incorporates the elements of the State's definition for medical necessity and notes that Beacon can make medical necessity determinations for the purpose of utilization control (see Section I. and Section II.E in 202L Medical Necessity Determinations). The list of covered diagnoses is stipulated by HCIs' Medicaid contract (see Exhibit I-Covered Behavioral Health Services and	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Diagnoses). The level of Care guidelines are the basis for any limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals. Each level of care guideline contains evidence informed inclusion and exclusion criteria designed to authorize care for the members who would reasonably be expected to benefit from the service. Criteria are outlined to continue authorization for members who are progressing in treatment or who need to have treatment plans adjusted by providers to address any lack of progress. Care managers actively work with providers during reviews, based on the LOC criteria to shape treatment so that it will achieve the care needs of members.	
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3–10-16-104(3)(B)* Contract: Exhibit B-2—14.6.5.2.1	**Evidence used:** 1. HCI Administrative Services Agreement, pages 14-16 2. 202L-- Medical Necessity Determinations, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. This responsibility is defined in the HCI Administrative Services Agreement. The RAE is committed to ensuring access to and coverage of services that are in parity with all medical/surgical benefits in the same classification furnished to members.	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The amount, duration and scope of covered behavioral health services is limited by only the determination of medical necessity (see Section II.F of 202L Medical Necessity Determinations**).** Beacon may place limits on services for utilization control, as agreed to by HCI, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members. Services that are determined to be medically necessary are not otherwise limited. For example, there are no financial, episode of care, annual, or lifetime benefit limits. Services under this health plan are not less than the amount, duration, and scope of services that are available under fee-for-service Medicaid.	
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*	**Evidence used:** 1. 202L-- Medical Necessity Determinations, Section II.G. 2. Exhibit H Developmental Disability and Traumatic Brain Injury Guidance, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. According to Beacon's policy titled "202L Medical Necessity Determinations" (see Section II.G.), the presence of a co-morbid intellectual or	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service. It is noted that such conditions often co-occur with behavioral health disorders. This can present challenges for providers who are trying to assess and treat an individual's covered behavioral health needs. A guidance document for the evaluation and treatment of intellectual or developmental disabilities **(see** Exhibit H Developmental Disability and Traumatic Brain Injury Guidance**)** was developed by the previous Behavioral Health Organizations in collaboration with the Community Centered Boards, developmental disability professionals, member advocates, and other key stakeholders, in the interest of fulfilling their responsibilities under the Colorado Medicaid Program. This guidance document was adopted by the BHOs, and it was subsequently adopted by the RAEs as part of the ACC program. A similar document was developed for the evaluation and treatment of individuals with a covered mental illness and a co-morbid Traumatic Brain Injury. This guidance document was adopted by the RAE as part of the ACC program contract (See Exhibit H and Section II.G. of 202L Medical Necessity Determinations).	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*	**Evidence used:** 1. 202L--Medical Necessity Determinations, Section II.H. **2.** Exhibit I-Capitated BH Benefit Covered Services and Diagnoses, entire document **Narrative:** This required element is delegated to Beacon Health Options by HCI. According to Beacon's policy titled "202L Medical Necessity Determinations", all medically necessary covered treatments for covered behavioral health diagnoses are covered, regardless of any co-occurring conditions (see Section II.H. of 202L Medical Necessity Determinations). The list of covered services and diagnoses is provided in Exhibit I-Covered Behavioral Health Services and Diagnoses.	*For Information Only*
7. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.	**Evidence used:** 1. 202L--Medical Necessity Determinations, Section II.A. **Narrative:** This required element is delegated to Beacon Health Options by HCI. Medically necessary services are needed for the diagnosis or treatment of health impairments and also to prevent deterioration in functioning as a result of a covered mental health disorder (see Section II.A. of 202L Medical Necessity Determinations).	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* Contract: Exhibit B-2—2.1.62 10 CCR 2505-10 8.076.1.8		
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-2—14.8.2	**Evidence used:** 1. 204L--Intake Data Collection Initial Auth HLOC, entire policy 2. 202L--Medical Necessity Determinations, section IV 3. 206LData Collection Continued Auth HLOC, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon policies clearly define and outline the procedures and information needed for initial and continuing authorization of services (see 204L Intake Data Collection Initial Auth HLOC**)**. The first step in the process is to gather the clinical data and determine if medical necessity is being met (see 202L Medical Necessity Determinations and 204L Intake Data Collect Initial Auth HLOC). If additional services are requested, the process for conducting continuing reviews is reflected in 206L--Continued Authorization HLOC.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-2—None	**Evidence used:** 1. 408L Care Management Documentation Audit, entire policy 2. CCM Audit Tools, entire document 3. CSNT 116.6--Inter-Rater Reliability, entire document **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon has a policy and procedure in place that outlines the process to ensure consistent application of the review for authorizing decisions (see 408L Care Management Documentation Audit). Beacon clinical care managers complete quarterly peer audits utilizing a web-based audit tool that focuses on the content of documentation for UM decision making (see CCM Audit Tools). The audit reviews inpatient and acute treatment unit (ATU) admissions that occurred the previous quarter. Each CCM has 2 admissions per month that are randomly selected, and then their peers review the documentation in Care Connect. Care Connect is Beacon's integrated system for authorization, documentation, and claims management. The cases are selected by the UM Manager and distributed to the CCM team to complete. The web-based tool calculates the scoring for the documentation audit, which includes timeliness of decision making and content elements. If the results of the audit are below the standard of 85% compliance, then a corrective action plan is implemented to improve staff knowledge. Staff must complete the plan and achieve	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	competency. Results are reported to the team and to the Clinical Peer Advisor. Beacon also requires clinical staff to take an annual inter-rater reliability test (IRR) to evaluate the appropriateness of clinical decision-making and to establish a systematic method to monitor the consistency with which clinicians and Peer Advisors apply medical necessity criteria in decision-making and documentation. Clinical staff must achieve a passing score of 80% on this examination; if they do not achieve a passing score, then they must complete a corrective action plan to achieve competency. See CSNT 116.6--Inter-Rater Reliability, entire document. Beacon relies on multiple other methods to ensure consistency in decision-making. These methods include individual and group supervision, weekly rounds, peer audits, and live or recorded call supervision/call monitoring. See CSNT 116.6-Inter-Rater Reliability—Entire Document.	
10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-2—14.8.2.5	**Evidence used:** 1. 202L--Medical Necessity Determinations, Section IV, G 2. 303L-- Peer Advisor Adverse Determinations, section IV.A.3 3. 203L--Medical Necessity Determination Timelines, Section IV.A **Narrative:**	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This required element is delegated to Beacon Health Options by HCI. Beacon policies direct staff to contact the provider, when necessary, for a review determination. Authorizations or denials of services involve immediate telephonic notification of providers (see 203L Medical Necessity Determination Timelines). In addition, Beacon policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial or continued authorization is denied (see Section IV.A.3. of 303L Peer Advisor Adverse Determinations). If providers fail to request additional services, Beacon staff will reach out to coordinate with the provider to determine whether the member has discharged from care. If there is not enough information available to make a determination, the provider is notified along with details about the information needed. Attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions (see Section IV.A.6. of 203L Medical Necessity Determinations, Lack of Information and Notification Timelines).	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B-2—14.6.6	**Evidence used:** 1. 303L--Peer Advisor Adverse Determinations, Section II.C **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon policy 303L Peer Advisor Adverse Determinations notes that denial decisions can be made by only qualified Peer Advisors, as defined in Section II.C.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR 438.210(c)* Contract: Exhibit B-2—8.6.1 10 CCR 2505-10 8.209.4.A.1	**Evidence used:** 1. 203L--Medical Necessity Determination Timelines, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care (see Section IV of 203L Medical Necessity Determination Timelines**).**	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service.	**Evidence used:** 1. 203L--Medical Necessity Determination Timelines, section IV **Narrative:** This required element is delegated to Beacon Health Options by HCI. In Beacon's policy titled "203L Medical	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-2—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	Necessity Determination Timelines", the following timeframes are noted for mailing of Notices of Action: • All authorization decisions are made as expeditiously as the member's health condition requires (see Section IV, A.2 and B.5). • For standard service authorization decisions that deny or limit services, within 10 calendar days of the receipt of request for service (see Section IV.B.5). • If the provider indicates that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, Beacon's UM team makes an expedited authorization. For expedited decisions, providers are notified by telephone when a decision is made and letters are mailed no later than 72 hours from the receipt of the request for services (see Section IV.B.7).	
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-2—8.6.6.1, 8.6.8.1	**Evidence used:** 1. 203L--Medical Necessity Determination Timelines, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon rarely extends decision timeframes; however, when extensions are made, the policy titled "203L Medical Necessity Determination Timelines**"** provides the guidelines that are followed when extended decision timeframes (see Section IV.B.5**).**	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Authorization Decisions are made as quickly as the member's health condition requires, but no longer, than ten (10) calendar days following the request for service for standard authorization decisions that deny or limit services. The RAE may extend the service authorization notice timeframe up to fourteen (14) additional days if the member or provider requests extension, or if the RAE shows a need for additional information and how the extension is in the member's best interest. The RAE will give the member written notice of the reason for the extension and the Member's right to file a grievance if they disagree with this extension.	
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on denial notices. (Reviewed in Member Information standard.) **Evidence used:** 1. 307L_Member Information Requirements_HCI, entire policy *Misc. 2. NOABD_HCI, entire document *Misc. **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon follows the policy titled "307L_Member Information Requirements_HCI when developing member-facing materials. All commonly used	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member materials that were originally created in English are translated into Spanish, which has been deemed as a prevalent language by the state. We recognize that a large proportion of Medicaid enrollees have low health literacy, thus we follow guidelines developed by CMS in developing the Beacon member materials policy for low literacy readers. For example, when we present a concept that may be unknown to a low literacy reader, we offer a definition in simple language. The Notice of Adverse Benefit Determination (NOABD_HCI) letter is translated into Spanish, and we are prepared to translate it into other languages, when necessary. We test our materials to ensure they are at or below the 6th grade reading level.	
Findings: HCI policies and other submitted evidence demonstrated that template NOABDs used for UM denials were written in a language easy to understand and informed the member of availability of the letter in other languages and alternative formats. However, HSAG found eight of 10 denial record reviews were *Not Met* for "correspondence with the member was easy to understand." HCI's notice incorporated language such as "exclusionary criteria," "emphasis," and "less restrictive" to describe the reason for adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.		
Required Actions: HCI must ensure that the NOABD in its entirety is written in language that is easy for a member to understand.		
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and	**Evidence used:** 1. NOABD_HCI, entire document *Misc. 2. Appeal Guide_HCI, entire document *Misc. 3. 203L--Medical Necessity Determinations Timelines, Section IV.C.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* Contract: Exhibit B-2—8.6.1.5–8.6.1.12 10 CCR 2505-10 8.209.4.A.2	**Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon ensures that members receive Notices of Adverse Benefit Determination (NOABD_HCI) that contain all required elements. In an effort to only include elements in the letter which pertain specifically to the member in question, Directions on how to file a Grievance or Appeal is included within the Notice of Adverse Benefit Determination letter. All Notices of Adverse Benefit Determination (NOABD_HCI) include the following information: • Specific information about the services which have been denied (e.g., level of care, dates of services). • Identification of the person making the determination and his or her credentials. • Explanation of the reasons for denial. • Information about the member's right to file an appeal, or the provider's right to file an appeal when the provider is acting on behalf of the Member as the member's Designated Client Representative. • Member's right to request a State Fair Hearing. • Instructions for filing an appeal or grievance, including due date.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Explains the circumstances under which an expedited resolution of an appeal is available, and how to request it. • Explains the Member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of continued services.	
17. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), (II), and (III)* Contract: None	**Evidence used:** 1. NOABD_HCI, entire document *Misc. **Narrative:** This required element is delegated to Beacon Health Options by HCI. All Notices of Adverse Benefit Determination letters for denial of behavioral, mental health, or SUD benefits includes the following statements in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for behavioral health care, if the member believes his	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	or her rights under the MHPAEA have been violated. A statement specifying that members are entitled, upon request to the RAE and free of charge, to a copy of the medical necessity criteria for any behavioral, mental health, or SUD benefit.	
18. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 10 CCR 2505-10 8.209.4.A.3	**Evidence used:** 1. 203L--Medical Necessity Determination Timelines, Section IV **Narrative:** This required element is delegated to Beacon Health Options by HCI. In Beacon's policy titled "Policy 203L Medical Necessity Determination Timelines", the following outlines the timeframes noted for mailing of Notices of Action: • For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 days (see Section IV.K) • At the time of the action for denial of payment. (see Section IV.B.4 and Section IV.M) • For standard service authorization decisions that deny or limit services, within 10 calendar days of the receipt of request for service (see Section IV.H and Section IV.I) • For expedited authorization decisions, within 72 hours (see Section IV.B.7)	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• For extended service authorization decisions, no later than the date the extension expires (see Section IV.F to Section IV.I). • For service authorization decisions not reached within the required timeframes, on the date timeframes expire (see Section IV. A.5)	
19. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.	**Evidence used:** 1. 203L--Medical Necessity Determination Timelines, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. See Section IV.B of 203L Medical Necessity Determination Timelines.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)		
20. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-2—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)	**Evidence used:** 1. 203L--Medical Necessity Determination Timelines, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy details the requirements to send written notification to the member and to carry out the determination as expeditiously as the member's health condition requires. The written notice also includes information about their right to file a grievance, if he or she disagrees with that decision. Written notification requirements can be found in Beacon's policy titled "203L Medical Necessity Determination Timelines**"** in the following locations:	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• IV.F.3.a • IV.G.3.a • IV.H.2-3 • IV.I.2 • IV.I.3 The policy also outlines the fact that authorization decisions are made as required by the member's health condition and no later than the date the extension expires. See the following sections: • IV.F.1 • IV.G.1 • V.H.1 • IV.I.1	
21. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-2—14.8.6	**Evidence used:** 1. CSNT 117.5 Objectivity in Clinical Decision Making, entire policy **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. (see CSNT 117.5 Objectivity in Clinical Decision Making). During new employee orientation and annually thereafter, Beacon staff receives training regarding conflict of interest and employee code of conduct, including signing an annual	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	attestation agreeing with policies that they are not given incentives to deny or limit care for members.	
22. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.33	**Evidence used:** 1. 270L--Emergency and Post-Stabilization Services, section II.A 2. Health First Colorado Member Handbook, p. 13 *Misc. 3. Provider Handbook2019_HCI,*Misc., p. 24 **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency and Post-Stabilization Services" defines emergency medical conditions that correspond with the State's definition of this term. Members receive information in the Member Handbook about what defines an emergency or crisis and how to obtain emergency services. Beacon staff assist members and direct them to the nearest facility/ER when there is any question of an emergency medical condition. The Provider Handbook also includes the following definition: Emergency Services • Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: a. placing the patient's health in serious jeopardy b. serious impairment to bodily functions	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	c. serious dysfunction of any bodily organ or part • Emergency services do not require prior authorization. • Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.	
23. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.34	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section II.C. 2. Provider Handbook2019_HCI, p. 24 * Misc. **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency and Post-Stabilization Services", Section II.C provides this exact definition of Emergency Services. This definition is also given to providers in the Provider Handbook2019_HCI as follows: Emergency Services • Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: a. placing the patient's health in serious jeopardy b. serious impairment to bodily functions	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	c. serious dysfunction of any bodily organ or part • Emergency services do not require prior authorization. • Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.	
24. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.74	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section II.D. 2. Provider Handbook2019_HCI, p. 65 *Misc. **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency and Post-Stabilization Services" provides this exact definition of Emergency Services This definition is also given to providers in the Provider Handbook2019_HCI: Post-stabilization Services: Services that are provided in relationship to an emergency medical condition and are provided after a member is stabilized in order to maintain the stabilized condition.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-2—14.5.6.2.2	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section I.A., **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "**270L Emergency and Post-Stabilization Services"** provides an overview of how emergency services are covered and reimbursed. Members can access these services without prior authorization and claims for emergency services are accepted and paid for to any provider, regardless of network status.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are*	**Evidence used:** 1. 270L Emergency Post-Stabilization Services, Section I.C.1 **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency Post-Stabilization Services" clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble) • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-2—14.5.6.2.6		
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B-2—14.5.7.2.8	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section I.D **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency and Post-Stabilization Services) contains the following specific language in Section I.D: Beacon does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, Beacon, the Department of the member's screening and treatment within 10 days of presentation for emergency services.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-2—14.5.6.2.9	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section I.E. **Narrative:** This required element is delegated to Beacon Health Options by HCI. The Beacon policy titled "270L Emergency and Post-Stabilization Services" releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. The policy states the following: • Beacon does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, or for post stabilization services, regardless of whether these services were obtained through COS_EC or not. Members are not charged for these services.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-2—14.5.6.2.10	**Evidence used:** 1. 270L Emergency and Post-Stabilization-Services, Section I.F **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and Post-Stabilization Services**"** states the attending physician/facility makes decisions independent of any contact with the RAE (or Beacon) regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered. The policy states the following: • Beacon allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on COS_EC (Beacon) who is responsible for coverage and payment.	
30. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* Contract: Exhibit B-2—14.5.6.2.11	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section I.H **Narrative:** This required element is delegated to Beacon Health Options by HCI. The RAE (or Beacon) is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative, regardless of whether they are provided within or outside of the RAE's network of providers. Section I.H. of	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

	Beacon's policy titled "270 Emergency and Post-Stabilization Services clearly states this financial responsibility. The policy reads as follows:
	• Beacon is financially responsible for post stabilization care services obtained within or outside the network that are:
	  • Pre-approved by a plan provider or a representative of Beacon.
	  • Not pre-approved by a plan provider or Beacon representative but are administered to maintain the member's stabilized condition within 1 hour of a request to Beacon for pre-approval of further post stabilization care services.
	  • Not pre-approved by a plan provider of Beacon representative but are administered to maintain, improve, or resolve the member's stabilized condition if:
	  • Beacon does not respond to request for pre-approval within 1 hour
	  • Beacon cannot be contacted
	Beacon representative and the treating physician cannot reach agreement concerning the member's care and the Beacon Medical Director is not available for consultation. In this situation, the Beacon representative will assist the treating physician in arranging consultation with the Beacon Medical Director and the treating physician may continue with care of the member until the Beacon	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Medical Director is reached or any of the following criteria are met, and at this time the financial responsibility of Beacon ends: • An in network physician with privileges at the treating hospital assumes responsibility for the member's care • An in network physician assumes responsibility for the member's care through transfer • A Beacon representative and the treating physician reach an agreement concerning the member's care • The member is discharged	
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-2—14.5.6.2.12	**Evidence used:** 1. 270L Emergency and Post-Stabilization-Services, Section I.H **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further post-stabilization care services. Beacon's policy	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	titled "270L Emergency and Post-Stabilization Services states the following: • Beacon is financially responsible for post stabilization care services obtained within or outside the network that are: • Pre-approved by a plan provider or a representative of Beacon. • Not pre-approved by a plan provider or Beacon representative but are administered to maintain the member's stabilized condition within 1 hour of a request to Beacon for pre-approval of further post stabilization care services. • Not pre-approved by a plan provider of Beacon representative but are administered to maintain, improve, or resolve the member's stabilized condition if: • Beacon does not respond to request for pre-approval within 1 hour • Beacon cannot be contacted • Beacon representative and the treating physician cannot reach agreement concerning the member's care and the Beacon Medical Director is not available for consultation. In this situation, the Beacon representative will assist the treating physician in arranging consultation with the Beacon Medical Director and the	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	treating physician may continue with care of the member until the Beacon Medical Director is reached or any of the following criteria are met, and at this time the financial responsibility of Beacon ends: • An in network physician with privileges at the treating hospital assumes responsibility for the member's care • An in network physician assumes responsibility for the member's care through transfer • A Beacon representative and the treating physician reach an agreement concerning the member's care • The member is discharged	
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation,	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section I.H **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon is financially responsible for post stabilization care services obtained within or outside the network that have not been pre-approved by a plan provider or other organization representative but are	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-2—14.5.6.2.12	administered to maintain the member's stabilized condition if the following circumstances are met: • The RAE's UM delegate (i.e., Beacon) does not respond to a request for pre-approval within one hour. • The RAE's UM delegate cannot be contacted. • The RAE's representative (i.e., Beacon) and the treating physician cannot reach an agreement concerning the member's care and the RAE's Medical Director is not available for consultation. In this situation, the RAE must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with the care of the patient until a plan physician is available to consult on the treatment or until one of the criteria in 422.113 (c)(3) is met. Beacon's policy titled "270L Emergency and Post-Stabilization Services" states this financial responsibility.	
33. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or	**Evidence used:** 1. 270L Emergency and Post-Stabilization Services, Section I.H **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency and Post-Stabilization Services" (see Section I.H) relays financial responsibility for post-stabilization care services	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-2—14.5.6.2.14	that have not been pre-approved ends when the following is met: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care; • A plan physician assumes responsibility for the member's care through transfer; • The organization's representative and the treating physician reach an agreement concerning the member's care; • or the member is discharged.	
34. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-2—14.5.6.2.13	**Evidence used:** 1. 270L Emergency and Post Stabilization Services, Section I.E. **Narrative:** This required element is delegated to Beacon Health Options by HCI. Beacon's policy titled "270L Emergency and Post Stabilization Services" states that members are not charged for post-stabilization services regardless of whether the services are obtained through a Beacon network provider or not. The policy states the following: Beacon does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, or for post stabilization	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services, regardless of whether these services were obtained through Beacon or not. Members are not charged for these services.	

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	29
				Total Score ÷ Total Applicable		=	97%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a PCMP and BH network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Adult mental health providers • Pediatric mental health providers • SUD providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers • Family planning providers *42 CFR 438.206(b)(1)* Contract: Exhibit B-2—9.5.1.1, 9.5.1.3	**Evidence Used:** 1. PRCO_003_Network Policy_HCI, sections IV.A-B and V.A 2. R4_NetworkAdequacyPln 07-19_HCI, entire document 3. R4 NetworkRptQ4FY18-19_HCI, pg. 11-14 4. ProviderDirectory_HCI, entire document **Narrative:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon operates according to a policy that outlines the procedures involved to evaluate and maintain a comprehensive provider network. Beacon's provider network serves the needs of all eligible Health First Colorado (Medicaid) members including, those with limited English proficiency or physical or mental disabilities as outlined in the PRCO_003_Network Policy_HCI sections IV.A-B for primary care providers and V.A for behavioral health providers. The policy PRCO_003_Network Policy_HCI Section VI.A outlines that the network is monitored "to ensure there is sufficient providers in the network to meet the requirements of the members for access to care to serve primary car and care coordination needs, serve all behavioral health needs, and allow for member freedom of choice' page 5.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	In addition to the established policy, Beacon maintains a Network Adequacy Plan (see R4_NetworkAdequacyPln07-19 V2_HCI, pg 1) to monitor development and maintenance of the primary care and behavioral health networks. The review includes the number of providers and specialties. Beacon Health Options performs ongoing monitoring of provider accessibility and availability. (R4 NetworkRptQ4FY18-19_HCI pg. 11-14) The number and diversity of providers included in the network is monitored to serve member needs based on expected population and member's historic utilization. The network is assessed annually and monitored on a quarterly basis to identify areas of need. Beacon focuses on provider recruitment based on the findings of the monitoring efforts to maintain sufficient providers within the network. (R4_NetworkAdequacyPln 07-19_HCI pgs. 6-7 and 8-13). Members are provided choice in providers across the HCI region. Members can find providers specific to their needs using the provider directory. The network includes an array of providers who can serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary. (ProviderDirectory_HCI Entire Document).	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* Contract: Exhibit B-2—9.1.4, 9.1.5, 9.1.7.1, 9.5.1.2, 9.5.1.4-6	**Evidence Used:** 1. PRCO_003_Network Policy_HCI, section VI.A 1-8 2. R4_NetworkAdequacyPln 07-19_HCI, entire document 3. R4 NetworkRptQ4FY18-19_HCI, entire document 4. ProviderDirectory_HCI, entire document 5. Provider Handbook 2019_HCI, pg. 16 *Misc. **Narrative:** Health Colorado Inc. (HCI) delegated this function to Beacon Health Options. Beacon developed a policy that outlines the procedures involved to establish guidelines to monitor the network. It also establishes elements to consider when evaluating a comprehensive provider network (PRCO_003_Network Policy_HCI section VI.A 1-8). Further, Beacon maintains a Network Adequacy Plan to address all needs of the NHP network and fill any disparity found (R4_NetworkAdequacyPln 07-19_HCI). Beacon Health Options monitors the availability of providers every quarter as well as annually. Through the R4 NetworkRptQ4FY18-19 (Entire Document), Beacon monitors network adequacy quarter over quarter. On a quarterly basis, the network is monitored for adequacy, through the Network Adequacy Report by	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reviewing the number of providers by types and specialty (See R4 NetworkRptQ4FY18-19_HCI pg. 11-14), provides accepting new members (pg. 15) by geographic location by time and distance to members (pg. 1-3), linguistic and cultural capacity (pg. 16-17), accessible facilities (pg. 17), and use of telemedicine (pg. 5-6). The monitoring completed by Beacon includes an assessment of member needs and expected utilization based off historic utilization data and member enrollment. Members are permitted to choice of providers across the HCI region outlined in Provider Handbook 2019_HCI pg. 14-15. The directory includes a diverse group of providers who can adequately serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary (See ProviderDirectory_HCI entire document).	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its PCMP provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-2—9.4.7	**Evidence Used:** 1. PRCO_003_Network Policy_HCI, section VI. E 2. R4 NetworkRptQ4FY18-19_HCI, pg. 1-3 3. R4 GeoAccessQ4FY18-19_HCI, entire document 4. HCI Minutes 02152019 revised_HCI, Pg. 3 **Narrative:** As the delegated entity for provider network for Health Colorado Inc. (HCI), Beacon Health Options monitors the provider network time and distance standards on an ongoing basis outlined in PRCO_003_Network Policy_HCI section VI.E and R4 NetworkRptQ4FY18-19_HCI pg. 1-3. Beacon Health Options summarizes the time and distance standards and utilizes geoaccess mapping to monitor compliance. Beacon Health Options conducts geoaccess mapping on a quarterly basis to review time and distance standards. Beacon uses the latest Quest Analytics Suite application to calculate the travel distance to the closest PCMP from member residence. An example of the geoaccess review is the R4 GeoAccessQ4FY18-19_HCI Entire Document which shows the time and distance analysis of adults in frontier counties for primary care providers.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	All of the pediatric and adult members in region 4 have a choice of at least two (2) PCMPs within the maximum distance for their county classification including the rural and frontier areas. (see R4 NetworkRptQ4FY18-19 pg. 1-3) Report details are reviewed during the monthly Provider Network Committee to address any identified gaps in access and availability. (HCI Minutes 02152019 revised_HCI, Pg. 3)	
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children:	**Evidence Used:** 1. PRCO_003_Network Policy_HCI, section VI. F 2. R4 NetworkRptQ4FY18-19_HCI, pg. 3-4 3. R4 GeoAccessQ4FY18-19_HCI, entire document **Narrative:** On behalf of Health Colorado Inc. (HCI), Beacon Health Options monitors the behavioral health provider network time and distance standards on an ongoing basis outlined in PRCO_003_Network Policy_HCI section VI.F which details the requirements for the behavioral health provider network to comply with the established time and distance standards.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)* *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-2—9.4.9	Beacon Health Options conducts geoaccess mapping on a quarterly basis to review time and distance standards. Beacon uses the latest Quest Analytics Suite application to calculate the travel distance to the closest PCMP from member residence. An example of the geoaccess review is the R4 GeoAccessQ4FY18-19_HCI Entire Document which shows the time and distance analysis of adults in frontier counties for behavioral health providers. The majority of HCI members (99%) have access to at least two (2) behavioral health and SUD providers within the RAE region at the maximum distance for their county classification. (See R4 NetworkRptQ4FY18-19 pg. 3-4)	
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-2—9.2.7	**Evidence Used:** 1. PRCO_003_Network Policy_HCI, section IV.G 2. R4 NetworRptQ4FY18-19_HCI, pg. 11 3. R4_NetworkRept_Q4FY18-19_ HCI, Excel Tab Physical Health 4. Provider Handbook2019_HCI, pg. 15 *Misc. **Narrative:** On behalf Health Colorado Inc. (HCI) Beacon Health Options, contracts with PCMPs which have women's	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health care specialist within their practices. (See PRCO_003_Network Policy_HCI section IV.G). Beacon monitors network adequacy to ensure access to women's routine, and preventive health care services either as a member's assigned PCP or network provider. This is accomplished by monitoring the number of providers with provider type Obstetrics/Gynecology. The Network Adequacy Report captures the Provider Type of Obstetrics/Gynecology. (See R4 NetworRptQ4FY18-19_HCI pg. 11 and R4_NetworkRept_Q4FY18-19_HCI Excel Tab Physical Health). The majority of providers with specialty for women's routine and preventive health care services are reported under adult primary care. The Department has updated the template for second quarter of FY 2020, which will more accurately report providers with specialty for women's routine and preventive health care services. Additionally, as part of member choice, members may seek services from any primary care provider enrolled with Medicaid including to seek women's health care. (See Provider Handbook 2019_HCI pg. 15).	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-2—9.7.6	**Evidence used:** 1. Provider Handbook2019_HCI, pg. 14 *Misc. 2. 257L_Request for Second Opinion Policy_HCI, entire policy 3. Health First Colorado Member Handbook, pg. 11*Misc. **Narrative:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon has established a policy (257L_Request for Second Opinion Policy_HCI entire policy). As outlined in the policy it is essential to determine medical necessity of services provided and allowing members to seek a second opinion. Information for members regarding the process to request a second opinion can be found in the member handbook (Health First Colorado Member Handbook HCI pg. 11) Providers are educated about the member right and informed that this is completed at no cost to the member. (See Provider Handbook2019_HCI pg. 14).	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-2—14.6.1.1	**Evidence Used:** 1. 274L_Request for Out of Network Provider Policy_HCI, entire policy *Misc. 2. SCA_Letter_RAE_Practitioner_HCI, entire document 3. SCA_Letter_RAE_Facilities_HCI, entire document 4. Provider Handbook2019_HCI, pg. 15 *Misc. 5. Health First Colorado Member Handbook, pg. 11*Misc. **Narrative:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon has a policy and procedure specific for the RAE to process requests for covered services through an out of network provider in a timely manner. (See 274L_Request for Out of Network Provider Policy_HCI Entire policy). This policy details the approval process and situations where Single Case Agreements are approved for covered services by an out-of-network provider. In the member handbook, members are informed that they can ask to see a provider who may not be listed in the provider directory (see Health First Colorado Member Handbook, pg. 11*Misc.). Providers are sent an individual contract SCA_Letter_RAE_Practitoner_HCI and	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	SCA_Letter_RAE_Facilities_HCI. The SCA Letters reference the provider handbook that educate providers that they may not bill members for any services covered by Medicaid. (See Provider Handbook 2019_HCI pg. 15).	
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-2—14.7.11.1	**Evidence used:** 1. Provider Handbook2019_HCI, pg. 55-56 *Misc. 2. SCA_Letter_RAE_Practitioner_HCI, pg. 1 3. SCA_Letter_RAE_Facilities_HCI, entire document 4. NM306.3_SCA Contract Negotiation_HCI, entire document **Narrative:** Health Colorado Inc. (HCI) delegates this function to Beacon Health Options. Beacon Health Options requires that all out-of-network providers coordinate with Beacon in regards to payment. Included in the provider handbook (see Provider Handbook2019_HCI pg. 55-56), providers are educated that they are not able to balance bill members for Medicaid covered services. Providers are limited to charge Medicaid members for established co-pays for services received and cannot bill members directly for any services rendered. Beacon has a policy and procedure to contract and negotiate fee schedules (payment) for out- of -network providers approved for a Single Care Agreement. (See NM306.3_SCA Contract Negotiation_HCI entire document) Beacon's team managing the Single Case	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Agreement coordinates rate negotiation with Director of Provider Relations, to ensure it is within Colorado Medicaid rates. For Medicaid members, this process ensures the cost to the member is no greater than services furnished within the network. Included in the individual single case contract (See SCA_Letter_RAE_Practitioner_HCI, Pg 1 and SCA_Letter_RAE_Facilities_HCI, entire document) providers are informed and required to agree to the terms of the agreement, which details that the provider cannot hold the member financially liable for any portion of received services that are covered by Medicaid.	
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: 9.5.1.1, 9.5.1.3.10	**Evidence used:** 1. PRCO_003_Network Policy_HCI, Section IV.A.4 2. R4 NetworRptQ4FY18-19_HCI, pg. 11 3. R4_NetworkRpt_Q4FY18-19_HCI, Excel Tab Physical Health 4. Provider Handbook2019_HCI, pg. 15 *Misc. **Narrative:** On behalf of Health Colorado Inc. (HCI), Beacon contracts with PCMPs that offer family planning providers within their practices. (See PRCO_003_Network Policy_HCI, Section IV.A.4). Beacon monitors the network to ensure that there is	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	access to family planning providers either as a member's assigned PCP or in- network provider. Beacon monitors network adequacy to ensure that there is access to family planning providers. The Network Adequacy Report captures the Provider Type of Obstetrics/Gynecology. (See R4 NetworRptQ4FY18-19 pg. 11 and R4_NetworkRpt_Q4FY18-19_Excel Tab Physical Health). The majority of providers with specialty for family planning are reported under adult primary care. Additionally, as part of member choice, members may seek services from any primary care provider enrolled with Medicaid including to seek family planning services. (See Provider Handbook 2019_HCI pg. 15).	
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas.	**Evidence used:** 1. Provider Handbook2019_HCI, pg. 22, 23-24 *Misc. 2. Webinar Training_051719_HCI, pg. 39-41 3. PRCO_003_Network Policy_HCI, section VI.C 4. R4_Access to Care Audit_BH, entire document 5. HCI Minutes 02152019 revised_HCI, entire document	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B1—9.4.13	6. HCI Minutes 12102019_HCI, entire document 7. BH Access to Care_Webpage_HCI, entire document **Narrative:** On behalf of Health Colorado Inc. (HCI), Beacon Health Options establishes policies (PRCO_003_Network Policy_HCI, section VI.C) to ensure that timely access to care and services are met. All providers are required to meet the standards for timely access to care and services. The requirements are outlined in the provider handbook (See Provider Handbook2019_HCI pg. 23-24). In addition to the provider handbook, Provider training was offered on May 17, 2019. Training covered behavioral health access to care standards. (Webinar Training_051719_HCI pg. 39-41). Beacon monitors that access to care standards are met by performing outbound calls to practices to audit appointment availability. (R4_Access to Care Audit_BH Entire Document) results will be shared with Provider Network Committee (PNC). Providers are informed of these administrative audits through the Provider Handbook (Provider Handbook2019_HCI pg. 22). Additionally, the RAE website link https://www.healthcoloradorae.com/providers/clinical	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	-tools/ shares link on Access to Care Standards. (See BH Access to Care_Webpage_HCI). The Provider Network Adequacy Plan is reviewed by the Provider Network Sub-Committee (PNC) monthly to ensure that providers are meeting access and availability standards and to monitor improvements in any previously identified gaps. (HCI Minutes 02152019revised_HCI and HCI Minutes 12102019_HCI)	
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-2—9.4.2–9.4.4	**Evidence used:** 1. PRCO_003_Network Policy_HCI, section VI.B 2. Provider Handbook2019_HCI, pg. 22*Misc. **Narrative:** On behalf of Health Colorado Inc. (HCI), Beacon Health Options requires providers to meet minimum hours of operation, extended hours on evening and weekends, and alternatives to emergency department visits. Providers are required to offer Medicaid beneficiaries, have comparable hours of operation to commercial members. Beacon has a policy and procedure where this is outlined. (See PRCO_003_Network Policy_HCI section VI.B). This requirement is communicated to all providers through the Provider Handbook, which is an extension	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of the provider's contract with Beacon for HCI (See Provider Handbook2019_HCI pg. 22).	
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-2—9.4.6	**Evidence used:** 1. PRCO_003_Network Policy_HCI, section VI.B.1-2 2. Provider Handbook2019_HCI, pg. 22 *Misc. **Narrative:** On behalf of Health Colorado Inc. (HCI), Beacon Health Options requires providers to maintain emergency coverage 24 hours a day, seven (7) days a week. The policy PRCO_003_Network Policy_HCI section VI.B 1-2 outlines the requirement. Providers are communicated about the requirement through the See Provider Handbook2019_HCI pg. 22, which is an extension of the provider's contract with Beacon for HCI network.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-2—9.5.1.8	**Evidence used:** 1. Provider Handbook2019_HCI, pg. 22 *Misc. 2. PRCO_003_Network Policy_HCI, section VII. D 3. R4 NetworkRptQ4Fy18-19_HCI, pg. 9 4. Medicaid Access to care Standards_HCI, entire document 5. R4_Acces to Care Audit_BH, entire document	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Narrative: Health Colorado Inc. (HCI) delegated this function to Beacon Health Options. As a result, Beacon established a system to monitor timely access to care for members. As outlined in the policy and procedure, Beacon conducts outbound calls to practices to audit appointment availability (See PRCO_003_Network Policy_HCI section VII. D). Providers are informed of the administrative audits to through the Provider Handbook (See Provider Handbook2019_HCI pg. 22). Additionally, PCPs received a reminder about the access to care standards and informed "Beacon Health Options, on behalf of your RAE, conducts phone calls to network PCPs to ensure they meet the access to care standards" (See Medicaid Access to Care Standards_HCI Entire Document). Beacon Health Options performs ongoing monitoring to ensure providers are meeting requirements for access to care. All PCPs are audited every six months. Five percent (5%) of the behavioral health provider network within the region will be audited each month on rotating basis. Providers that do not meet standards receive education and are reviewed within 90 days of initial contact to ensure compliance is achieved. (PRCO_003_Network Policy_HCI section VII. D). All PCPs were audited in June/July of 2019 as a beta test to the audit workflow including survey questions and tracking system. These updates were incorporated	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	for the behavioral health audit conducted in December 2019 when the finalized policy was approved (PRCO_003_Network Policy_HCI Entire Document). Based on the audit in June/July 2019, 61% of the PCP practice locations contracted had an appointment available within seven (7) days for new patient and routine appointment (See R4NetworkRptQ4FY18-19 pg. 9). For behavioral health providers, the initial 5% of behavioral health provider locations in the region were audited in December 2019 with 50% of the provider having same day and routine appointment availability, and 17% had availability for a new member. The results showed that 33% compliance of all the standards. All providers audited will receive communication of the audit results and follow with education ahead of follow up auditing in 90 days. (See R4_Acces to Care Audit_BH Entire Document).	
Findings: HCI submitted its provider manual, Access to Care Standards Training Webinar, and BH Access to Care webpage to demonstrate its efforts to educate the provider network on the required State standards for timely access to care and services. HCI implemented a phone survey of a small sample of the behavioral health network to evaluate the availability and timeliness of RAE members scheduling appointments and obtaining care. The December 2019 survey results illustrated that all of the standards were met by four of the 12 providers surveyed. Of the eight providers that did not have access, four providers did not have appointment availability for new members and the other four providers were nonresponsive to HCI's outreach attempts.		
Required Actions: HCI must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). HCI must also ensure implementation of CAPs for providers that are not in compliance with these access to care standards.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* Contract: Exhibit B-2—7.2.1–7.2.6	**Evidence used:** 1. Provider Handbook2019_HCI, pg. 31, 87 *Misc. 2. Webinar Training_051719_HCI, pg. 2-38 3. ProviderDirectory_HCI, entire document 4. 311L Responding to Member Requests with Limited English Speaking Skills_HCI, entire policy *Misc. 5. Health-First-Colorado-Member-Handbook-Spanish, entire document *Misc. **Narrative:** On behalf of Health Colorado Inc. (HCI), Beacon Health Options requires all physical and behavioral health services to be offered in culturally competent manner. The provider handbook outlines the requirements for serving members in a culturally competent manner including; sensitivity to the member's particular language barriers, cultural beliefs, values and disabilities (See Provider Handbook2019_HCIpg 31, 87); principles for considering sex and gender identity (See pg. 87). Beacon makes critical written materials in Spanish and English and link members with interpreter services by contact Member Engagement Specialist (See 311L Responding to Member Requests with Limited English Speaking Skills_HCI and	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Health-First-Colorado-Member-Handbook-Spanish Entire Document) Provider webinar training was offered on May 17, 2019. It covered cultural competency training with the topics of (a) reducing health disparities by addressing cultural diversity, (b) clear communication and working with individuals with limited English Proficiency, (c) discus various populations and subcultures, (d) seniors and people with disabilities. It also included resources for language assistance and how to identify member's language proficiency (Webinar Training_051719_HCI pg. 2-38). Members are able to find network providers that have cultural competency training on the provider directory (See ProviderDirectory_HCI) and they can also contact Member Services for further assistance.	
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-2—9.1.4.5, 9.1.7.1, 9.5.1.2	**Evidence used:** 1. ProviderDirectory_HCI, entire document 2. Provider Handbook2019_HCI, pg. 23 *Misc. 3. ACC DCC Assessment Tool_HCI, entire document **Narrative:** On behalf of Health Colorado Inc. (HCI) Beacon Health Options, requires the providers to maintain an accessible facility. Provider Relations offers assessments of facilities upon request (See Provider	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Handbook2019_HCI, pg. 23). Provider Relations utilizes standard tool when providers request the assessment (See ACC DCC Assessment Tool_ HCI Entire Document). Members are able to find network providers that are ADA compliant on the provider directory (ProviderDirectory_HCI, Entire Document) and they can also contact Member Services for further assistance.	
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-2—9.5.1–9.5.4	**Evidence used:** 1. R4_NetworkAdequacyPln 07-19, entire document 2. R4 NetworkRptQ4FY18-19_HCI, entire document **Narrative:** The RAE has submitted in a timely manner and in the format specified by the State a Network Adequacy Plan to the State annually by July 31 (R4_NetworkAdequacyPln 07-19 Entire Document). Similarly, the Network Adequacy Report one month after the end of each quarter (R4 NetworkRptQ4FY18-19_HCI Entire Document).	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	94%

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* Contract: Exhibit B2—8.1 10 CCR 2505-10—8.209.1	Note: Federal requirements related to appeals apply only to MCOs and PIHPs (BH services of RAEs). The contract requires that regulations related to grievances apply to all RAE members. **Evidence Used:** 1. Complaint Delegation and Procedures_HCI, entire document 2. 305L_Appeal Policy_HCI, entire policy 3. 303L_Grievance Policy_HCI, entire policy 4. Complaint Guide_HCI, entire document 5. Appeal Guide_HCI, entire document *Misc. 6. State Fair Hearing Guide_HCI, entire document 7. NOABD_HCI, pages 3-8 *Misc. 8. Complaint Receipt Letter_HCI, entire document 9. Appeal Receipt Letter_HCI, entire document 10. Appeal Decision Letter_HCI, entire document 11. Appeal Job Aid_HCI, entire document 12. Complaint Job Aid_HCI, entire document 13. Provider Handbook2019_HCI, pages 12, 15-19 *Misc. 14. R4_GrieveAppealQ4_FY18-19_HCI, entire document 15. Meeting Minutes Example_HCI, pages 4-5 16. Accepted Grievance and Appeal Report_HCI, entire document **Description of Process:** Health Colorado (HCI) delegates the oversight of their grievance and appeal system to Beacon Health Options. Beacon has a grievance and appeals system in place for members in the HCI region. Beacon developed a Complaint Delegation and Procedures document that	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	outlines the responsibilities of Beacon and the responsibilities of the shareholders in handling grievances. See Complaint Delegation and Procedures_HCI, entire document. Beacon staff lead a quarterly Member Services Subcommittee with the shareholders to discuss complaint operations and to ensure fidelity to the complaint process. Beacon has a Member Engagement Specialist who is available to train the shareholder staff on the complaint requirements as well as documenting in HCI's feedback database. See Meeting Minutes Example_HCI, pages 4-5. Beacon follows their 305L Appeals Policy_HCI to process any appeal that a Member, Legal Guardian, or Designated Client Representative (DCR) initiates following the receipt of a Notice of Adverse Benefit determination for any denied behavioral health service. Beacon follows 303L_Grievance Policy_HCI that outlines the grievance process for Members, Legal Guardians or DCRs. The policy outlines that a grievance can be made for any behavioral or physical health service other than an adverse benefit determination notification. Beacon developed a Complaint Job Aid_HCI and an Appeal Job Aid_HCI to operationalize the systems of handling complaints and appeals. See Complaint Job Aid, entire document and Appeal Job Aid_HCI, entire document.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Beacon developed and implemented a Complaint Guide, an Appeal Guide, and a State Fair Hearing guide to assist members and providers with the procedures to make a complaint, request an appeal, or request a State Fair Hearing. See Complaint Guide_HCI, entire document, Appeal Guide_HCI, entire document, and State Fair Hearing Guide_HCI, entire document. These guides can be found on our website, www.healthcoloradorae.com: Health Colorado Complaint Guide Health Colorado Appeal Guide Health Colorado State Fair Hearing Guide The appeal process is outlined in the Notice of Adverse Benefit Determination letter which is sent to a member when there is any denial in behavioral health services. See NOABD_HCI, pages 3-8. If a member, legal guardian, or DCR requests an appeal, Beacon sends a receipt notification letter within two (2) business days and includes the Appeal Guide. See Appeal Receipt Letter_HCI, entire document. If an appeal is upheld, Beacon will send the State Fair Hearing Guide with the appeal determination letter so that Members know their right to request a State Fair Hearing. See Appeal Decision Letter_HCI, entire document. HCI sends a complaint receipt letter within two (2) business days when a member files a complaint. HCI attaches the complaint guide with the receipt letter so members have information about what to expect when filing a complaint. See Complaint Receipt Letter_HCI, entire document.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Beacon educates providers on the grievance and appeal process through the Provider Handbook2019_HCI. See Provider Handbook2019_HCI, pages, 12, 15-18. Beacon uses a feedback database to collect and track complaints and compliments. Advocates at the community mental health centers have access to the feedback database and are responsible for entering in processed complaints on a monthly basis. Beacon has a Member Engagement Specialist who enters any complaint that comes directly to Health Colorado. See Complaint Job Aid_HCI, entire document for a detailed explanation of the processes we use to collect complaint information. Beacon collects and tracks appeals in our shared drive which includes all of the information that members would want considered in their appeal. Beacon submits all appeals and grievances in a quarterly report to Healthcare, Policy and Financing forty-five days after the end of the reporting quarter. In This report, we track the totals of all complaints and appeals. See R4_GrieveAppealQ4_FY18-19_HCI, entire document. HCPF responds to the grievance and appeal reports which Beacon sends in. All grievance and appeal reports have been accepted. For an example of an accepted report, please see Accepted Grievance and Appeal Report_HCI, entire document.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.3 10 CCR 2505-10—8.209.2.A	Inform plan on-site that proposed federal rule changes include: Clarification that denial, in whole or in part, of a payment for a service does not include denial of a claim because it is not a "clean claim" and is not an adverse benefit determination. **Evidence used:** 1. 305L_Appeal Policy_HCI, pages 3-5 2. 303L_Grievance Policy_HCI, IIE pages 2-4 3. 274L_Request for Out of Network Provider Policy_HCI, page 1 *Misc. 4. Provider Handbook2019_HCI, pages 77-78 *Misc. 7. Appeal Guide_HCI, page 2 *Misc. **Narrative:** Health Colorado (HCI) has the definition of an adverse benefit determination located in internal and external documents which includes the required definitions as well as the definition in 42 CFR 438.400 which states that members who live in rural locations can exercise their right to obtain services outside of the network. Internally, Beacon follows grievance policy and the appeals policy, which has the full definition of an Adverse Benefit Determination for all staff to follow. See 305L_Appeal Policy_HCI, pages 3-5 and 303L_Grievance Policy_HCI, pages 2-4.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Beacon follows the 274L_Request for Out of Network Provider Policy_HCI, which outlines the single case agreement process. The policy describes the procedures Beacon will follow when Members request seeing an out-of-network provider, including members living in rural communities who want to exercise their right to obtain services outside of the network. See 274L_Request for Out of Network Provider Policy_, page 1. Externally, HCI has an appeal guide available for members which has a simplified definition of adverse benefit determination. This is located on our website, www.healthcoloradorae.com and is sent to members with the Appeal Receipt Letter. See Appeal Guide_HCI, page 2. Beacon has a Provider Handbook2019_HCI posted on the website available to providers that has the definition of an adverse benefit determination. See Provider Handbook2019_HCI, pages 77-78.	
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.5 10 CCR 2505-10—8.209.2.B	**Evidence used:** 1. 305L_Appeal Policy_HCI, page 3 2. 303L_Grievance Policy_HCI, page 2 3. Appeal Guide_HCI page 1*Misc. 4. Provider Handbook2019_HCI, page 78 5. Appeal and Complaint Training, Slide 3 **Narrative:** HCI defines “Appeal” as a review by the RAE of an adverse benefit determination made by the RAE. This definition is outlined in the	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	policies and procedures which we follow. Please see 305L_Appeal Policy_HCI, page 3 and 303L_ Grievance Policy_HCI on page 2. HCI communicates this appeal definition to Members through the Appeal Guide. See Appeal Guide_HCI, page 1 HCI communicates the appeal definition to provider through the Provider Handbook2019_HCI. See Provider Handbook2019_HCI, page 78. HCI developed a training on appeals and grievances for use with internal staff and external providers. The definition of an appeal can be found in this training. See Appeal and Complaint Training, Slide 3.	
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.42, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)	**Evidence used**: 1. 303L_Grievance Policy_HCI, page 2 2. 305L_Appeal Policy_HCI, page 6 3. Complaint Guide_HCI, page 1 4. Appeal Extension Letter_HCI, page 2 5. Quick Appeal Denied Request_HCI, page 2 6. Appeal and Complaint Training_HCI, slide 9 7. Provider Handbook2019_HCI, page 15 *Misc. **Narrative**: HCI defines grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. This definition is outlined in the policies which Beacon staff follow. See 303L_Grievance Policy_HCI, page 2 and 305L_Appeal Policy_HCI, page 6.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members can find the definition of a grievance in the complaint guide. HCI has simplified the definition to incorporate plain language guidelines in the Complaint Guide. The Complaint Guide can be found on our website. See Complaint Guide_HCI, page 1. HCI notifies Members that they can file a grievance if they disagree with HCI's decision to extend the time frame to make an appeal authorization decision. See Appeal Extension Letter_HCI, page 2. HCI notifies members that they can file a grievance if there request for an expedited appeal is denied. See Quick Appeal Denied Request_HCI, page 2. HCI has developed a training for internal staff and external providers on the definition of a grievance. See Appeal and Complaint Training, slide 9. The definition of a grievance can be found in the Provider Handbook2019_HCI. See Provider Handbook2019_HCI page 15.	
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member.	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 1 IA, C, Page 5 E 2. 303L_Grievance Policy_HCI, page 1, Id, Page 2 IIC 3. NOABD_HCI, pages 3, 4, 7, 8 *Misc. 4. Provider Handbook2019_HCI, pages 15-16 *Misc. 5. Complaint Guide_HCI, page 1 6. Appeal Guide_HCI, page 2, 5 *Misc. 7. State Fair Hearing Guide_HCI, page 2, 3	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420). *42 CFR 438.402(c)* Contract: Exhibit B2—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5	**Narrative**: HCI has provisions for who can file a grievance, appeal, or a State Fair Hearing. HCI allows anyone to act on a Member's behalf as long as the Member has authorized the individual to act as their Designated Client Representative (DCR) in writing. HCI follows 303L_Grievance Policy_HCI which states that anyone, including a health care professional, may act as a representative as long as the member names them in writing. See 303L_Grievance Policy_HCI, pages 1 and 2. HCI also follows 305L Appeals Policy which outlines that Members, Guardians, or a Member's DCR have the right to initiate an appeal or State Fair Hearing as long as Members have signed a DCR form or it is in writing. See 305L_Appeal Policy_HCI, Page 1 IA, C, Page 5 E. HCI provides the Designated Client Representative (DCR) Form on their website which Members can use to designate a representative to act on their behalf. See DCR Form_HCI. Members can sign this form designating an individual to act on their behalf in the grievance, appeal, or state fair hearing process. Members are made aware of this right in the Complaint Guide, Appeal Guide, and State Fair Hearing Guide. See Complaint Guide_HCI, page 1, Appeal Guide_HCI, page 2, and State Fair Hearing Guide_HCI, page 2. HCI sends Members a Notice of Adverse Benefit Determination (NOABD) Letter when services have been denied for behavioral health treatment. The letter outlines that a Member, Guardian, or someone they designate can request an appeal on their behalf. The letter notes that if a member designates their provider to file an	

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	appeal on their behalf, that provider cannot request continuation of services. See NOABD_HCI, pages 3, 4, 7, 8. HCI developed an Appeal Guide and a State Fair Hearing Guide that states that members can ask for continuation of services during their appeal. We outline that providers cannot ask for continuation of services on a Member's behalf. See Appeal Guide_HCI, page 5 and State Fair Hearing Guide_HCI, page 2-3. Beacon educates providers on who can file an appeal or grievance in the Provider Handbook2019_HCI. See Provider Handbook2019_HCI, Pages 15-16	
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)* Contract: Exhibit B2—8.3 10 CCR 2505-10 8.209.4.C	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 7, IV A 3 2. 303L_Grievance Policy_HCI, page 1 Ie 3. 311L_Responding to Member Requests with Limited English Speaking Skills_HCI, page 2 *Misc. 4. NOADB_HCI, page 3 *Misc. 5. Complaint Guide_HCI, page 2-3 6. Appeal Guide_HCI, page 3 *Misc. 6. Complaint Receipt Letter_HCI, page 2 7. Appeal Receipt Letter_HCI, page 2 **Narrative**: HCI assists members who request help with completing any forms and/or using any auxiliary aids for both grievances and appeals. HCI follows Beacon's internal policies which outline that we will assist members with filling out forms or providing interpreter	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services at Member's request. Please see 305L_Appeal Policy_HCI, Page 7 and 303L_Grievance Policy_HCI, page 1. HCI also follows 311L_Responding to Member Requests with Limited English Speaking Skills_HCI to link Members with interpreter services. See 311L_Responding to Member Requests with Limited English Speaking Skills_HCI, page 2. HCI developed a complaint guide and an appeal guide to educate members on how HCI will assist them with filling out any forms related to their grievance or appeal as well as helping members utilize interpreter services. See Complaint Guide_HCI, pages 2-3 and Appeal Guide_HCI, page 3. These guides are kept on our website and are mailed to members with the Complaint Receipt Letter and Appeal Receipt Letter. HCI's toll free numbers and TTY/TTD numbers are provided in these letters. Beacon has a Member Engagement Specialist who will link Members with any interpreter services that Members request. See Complaint Receipt Letter_HCI, page 2 and Appeal Receipt Letter_HCI, page 2.	
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following:	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 5D, 7B, 9E 2. 303L_Grievance Policy_HCI, page 7 #11 3. Complaint Guide_HCI, page 2 4. Appeal Guide_HCI, page 3 *Misc. 5. NOABD_HCI, pages 4, 5, 8 *Misc. 6. Appeal Decision Letter_HCI, page 2 7. Quick Appeal Denied Request_HCI, page 2 8. Appeal Receipt Letter_HCI, page 2 9. Complaint Receipt Letter_HCI, page 2	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B2—8.5.4, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	10. Appeal Job Aid_HCI, pages 3, 11 **Narrative***:* Health Colorado ensures that the individuals who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual. HCI also ensures that these individuals have the appropriate clinical expertise to make a decision. HCI follows Beacon's 305L Appeal Policy which defines a Peer Advisor as a health professional employed or contracted with the RAE on page 5. The Peer Advisor has a current and active, unrestricted license to practice medicine or a health profession. The Peer Advisor is board certified and in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment and is not the individual who made the original non-certification nor the subordinate of one who made decision. Peer advisors are the individuals who review denial decisions. On page 7, the policy outlines that a request for an expedited appeal will be reviewed with a Peer Advisor. On page 9, the policy outlines the types of appeals that the Peer Advisor will review. See 305L_Appeal Policy_HCI, pages 5D, 7B, 9E. HCI's appeal decision letter has a standard paragraph with an attestation that the Peer Advisor was not involved in HCI's original determination and documents the scope of the Peer Advisor's licensure. See Appeal Decision Letter_HCI, page 2 HCI follows Beacon's 303L_Grievance Policy_HCI which states that the staff person investigating the grievance shall ensure that	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the individual who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making, nor are they a subordinate of that individual and who have the appropriate clinical expertise in treating the client's condition if deciding a grievance that involves clinical issues. See 303L_Grievance Policy_HCI, page 7. Beacon developed an Appeal Job Aid_HCI which demonstrates the process staff follow when we receive a request for an expedited appeal and who can process the appeal. HCI's Member Engagement Specialist will review the request with the medical director to see if the request meets criteria for an expedited request. If the medical director does not believe that it meets requirements, the member will receive a Quick Appeal Denied Request letter. The letter explains qualifications for the person who reviewed the request for the expedited appeal and the Member's right to file a grievance about the denied request. See Appeal Job Aid_HCI, pages 3, 11. See Quick Appeal Denied Request_HCI, page 2. HCI sends a Complaint Receipt Letter and an Appeal Receipt letter within two (2) business days of receipt of the complaint or appeal. The letter outlines that the person who will investigate the complaint or review the appeal will be a person who was not associated with their situation. See Complaint Receipt Letter_HCI, page 2 and Appeal Receipt Letter_HCI, page 2. HCI sends a Complaint Guide and an Appeal Guide in these letters which also explains that those who make decisions on grievances and appeals are people who were not involved in any previous level of review or decision-making for the Member nor a subordinate of that individual. These guides can be found on our website. See Complaint Guide_HCI, page 2 and Appeal Guide_HCI, page 3.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI sends a Notice of Adverse Benefit Determination letter (NOABD) when there is any denial of coverage. The letter explains that he person who makes a decision regarding an appeal or complaint was not involved in the original decision, nor a subordinate of that individual and will have the necessary clinical experience. See pages NOABD_HCI, pages 4, 5, 8.	
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B2—None	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 2G, page 7c 2. 303L_Grievance Policy_HCI, page 7 #11 3. NOABD_HCI,page 4 *Misc. 4. Appeal Decision Letter_HCI, page 2 5. Complaint Guide_HCI, page 2 6. Complaint Receipt Letter_HCI, page 2 7. Appeal Guide_HCI, page 4-5 *Misc. 8. Appeal Receipt Letter_HCI, page 2 9. Example of Collecting Appeal Data_HCI, entire document **Narrative:** Health Colorado ensures that the individuals who make decisions on grievances and appeals take into account all comments, documents, records and other information submitted by the Member or the Member's representative without regard if the information was submitted or considered in the initial adverse benefit determination. HCI follows Beacon's 305L_Appeal Policy_HCI and 303L_Grievance Policy_HCI. These policies outline procedures that those who make decisions on grievances or appeals will take	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	into account all information provided by the Member. See 305L_Appeal Policy_HCI, pages 2 and 7 and 303L_Grievance Policy_HCI, pages 7 and 11. Members are made aware that they can provide additional information for their complaint or appeal in the Complaint Guide and Appeal Guide. See Complaint Guide_HCI, page 2 and Appeal Guide_HCI, page 4-5. These guides are sent along with the complaint receipt letter and appeal receipt letter. See Complaint Receipt Letter_HCI, page 2 and Appeal Receipt Letter_HCI, page 2. The guides can also be found on the website at www.healthcoloradorae.com. Members are also informed that they can provide information for an appeal in the Notice of Adverse Benefit Determination letter. See NOABD_HCI, page 4. To demonstrate that HCI takes into account all comments, documents, records and other information submitted by the Member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination, see Example of Collecting Appeal Data_HCI. HCI's Member Engagement specialist compiles all information received from Member/DCR into a secure shared drive. This information is sent to the Peer Advisor. The member is informed of the information used in making the appeal decision in the appeal decision letter. See Appeal Decision Letter_HCI, page 2.	
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.D	**Evidence used**: 1. 303L_Grievance Policy_HCI, pages 1 Ic, 5-6 IV2 2. Complaint Guide_HCI, page 2 3. NOABD_HCI, page 8 *Misc. 4. Provider Handbook2019_HCI, page 15 *Misc. 5. Appeal and Complaint Training_HCI, slides	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	9, 10 6. Lunch and Learn Flyer_HCI, entire document **Narrative**: Health Colorado will accept a grievance orally or in writing. HCI follows the 303L_Grievance Policy_HCI which states that grievances can be filed orally or in writing. See 303L_Grievance Policy_HCI, pages 1 and 6. Members can file a grievance at their community mental health center or be directed to contact HCI's Member Engagement Specialist to assist in the grievance. Members are informed that they can file a grievance orally or in writing in HCI's Complaint Guide. See Complaint Guide_HCI, page 2. This Complaint Guide can be found on HCI's website. See www.healthcoloradorae.com. This information is also listed in the Notice of Adverse Benefit Determination Letter. See NOABD_HCI, page 8. Members are also made aware of their right to file a grievance orally or in writing at outreach events which HCI hosts to make members aware of their rights and responsibilities. See Lunch and Learn Flyer_HCI, entire document. HCI's Member Engagement Specialists also provides training for our staff who work in Beacon's Call Center. The staff are educated on Members' rights to make a grievance in writing or verbally. See Appeal and Complaint Training, slides 9, 10 Providers are made aware that Members can file a grievance orally or in writing in the Provider Handbook2019_HCI. See Provider Handbook2019_HCI, Page 15.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract: Exhibit B2—8.5.3 10 CCR 2505-10—8.209.5.A	**Evidence used**: 1. 303L_Grievance Policy_HCI, page 1 Ic 2. Complaint Guide_HCI, page 1 3. NOABD_HCI, page 8. *Misc. 4. Provider Handbook2019_HCI, page 15 *Misc. 6. Appeal and Complaint Training_HCI, Slide 11 7. Example of Complaint Received_HCI-entire document **Narrative**: Health Colorado allows Members to file a grievance at any time. HCI follows the 303L_Grievance Policy_HCI which states that Members can file a grievance at any time. See 303L_Grievance Policy_HCI, page 1. Members are made aware of this right to make a complaint at anytime in HCI's Complaint Guide. See Complaint Guide_HCI, page 1. This guide is on HCI's website, www.healthcoloradorae.com. This information is included in HCI's Notice of Adverse Benefit Determination Letter. See NOABD_HCI, page 8. HCI's Member Engagement Specialists also provides training for our staff who work in Beacon's Call Center. The staff are educated on Members' rights to make a grievance at any time. See Appeal and Complaint Training, slide 11. Providers are made aware that Members can make a grievance at any time in the Provider Handbook2019_HCI. See Provider Handbook2019_HCI, page 15.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI processed a past complaint which was received by a Member. HCI accepts complaints at any time, even when the complaint happened months or years ago. See Example of Complaint Received_HCI, entire document.	
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.B	**Evidence used**: 1. 303L_Grievance Policy_HCI, page 6 #5 2. Complaint Guide_HCI, page 2 3. Complaint Job Aid_HCI, page 3 4. Member Complaint Contact Record_HCI, entire document 5. Feedback Database_HCI, entire document 6. Complaint Receipt Letter_HCI, entire document 7. R4_GrieveAppealQ2_FY18-19 Summary_HCI, page 12 **Narrative**: Health Colorado sends Members a written acknowledgement letter within two (2) working days of the receipt of the grievance. HCI follows the 303L_Grievance Policy_HCI which states that HCI will send out an acknowledgement letter within two working days. See 303L_Grievance Policy_HCI, page 6. HCI's Member Engagement Specialist and Shareholder Advocates follow HCI's Complaint Job Aid which outlines the requirement to send an acknowledgement letter within two (2) working days to Members. See Complaint Job Aid_HCI, page 3. For an example of the letter that HCI sends out, please see Complaint Receipt Letter_HCI. The date the grievance is received sets the clock for the two-day turnaround time to send an acknowledgment letter. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This date is logged in the Member's Complaint Contact Record. See Member Complaint Contact Record_HCI. HCI has a feedback database with required fields for the date that the complaint was received and the date that the acknowledgement letter was sent. See Feedback Database_HCI, entire document. HCI sends quarterly reports to Colorado's Healthcare, Policy, and Financing (HCPF) department. For evidence that we are at 100% compliance in this area, please see R4_GrieveAppealQ2_FY18-19 Summary_HCI, page 12. HCI developed a Complaint Guide for Members which outlines what Members can expect when they make a complaint which includes a written receipt letter from HCI. See Complaint Guide_HCI, page 2.	
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on grievance resolution notices. (Reviewed in Member Information standard.) **Evidence used**: 1. 303L_Grievance Policy_HCI, page 7 #12, 7 #13 2. 307L_Member Information Requirements_HCI, page 1 *Misc. 3. Complaint Job Aid_HCI, pages 3, 4-7 4. Complaint Guide_HCI, page 3 5. Complaint Receipt Letter_HCI, page 2 6. Complaint Resolution Letter_HCI, entire document 7. Feedback Database Summary_HCI, entire document 8. R4_GrieveAppealQ2_FY18-19 Summary_HCI, page 12	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Narrative: Health Colorado aims to resolve each grievance and provides notice to the Member of the resolution of their grievance as expeditiously as possible. This resolution time frame is within 15 working days from the receipt of the grievance. There are times that HCI may need to extend this time frame at the Member's request or because HCI needs more time to resolve a grievance. The date the grievance is received establishes the clock for investigating and resolving the grievance. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The 15 working days is used to investigate the complaint such as gathering facts, consulting with others, and reviewing policies. When a resolution is found, the person handling the grievance notifies the member by letter. See Complaint Resolution Letter_HCI, entire document. HCI follows the 303L_Grievance Policy_HCI which outlines that those resolving grievances will attempt to resolve the grievance as expeditiously as possible and within the state and federal regulations of fifteen (15) working days. See 303L_Grievance Policy_HCI, page 7. The Member Engagement Specialist and/or Advocates who help to resolve the complaint follow Complaint Job Aid_HCI which outlines the fifteen (15) day business day time frames. See Complaint Flow Chart, entire document and Complaint Job Aid_HCI, pages 3-4. HCI developed a Complaint Guide to educate Members on the timeframes to resolve their complaint. See Complaint Guide_HCI, page 3. HCI also sends out a Complaint Receipt Letter which states	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the date that we hope to have a resolution to the complaint. See Complaint Receipt Letter_HCI, page 2. HCI uses their 307L Member Information Requirements_HCI to guide the content in the Complaint Resolution Letter. The Complaint Resolution Letter is written at an appropriate reading level and in a format to be easily understood by members. See 307L_Member Information Requirements, page 1. Beacon's Complaint Job Aid outlines the process to write a resolution letter that is easily understood by the member. See Complaint Job Aid_HCI, pages 4-7. HCI tracks the number of days it takes to resolve a grievance in the Feedback Database. See Feedback Database Summary_HCI, entire document. HCI sends HCPF a quarterly report which documents the number of business days to resolve a grievance. See R4_GrieveAppealQ_FY18-19 Summary_HCI, page 12	
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.G	**Evidence used**: 1. 303L_Grievance Policy_HCI, page 7 #14b and d 2. Complaint Resolution Letter_HCI, entire document 3. Complaint Job Aid_HCI, page 4 **Narrative**: Health Colorado sends a resolution letter which includes the disposition/resolution of the Member's grievance as well as the date the grievance was resolved within fifteen (15) business days. See Complaint Resolution Letter_HCI entire document.	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI follows 303L_Grievance Policy_HCI which states that we will include the disposition/resolution as well as date of resolution in the letter which is sent to the Member. See 303L_Grievance Policy_HCI, page 7. The Member Engagement Specialist and/or Advocates who process complaints follow the Complaint Job Aid which states that the results of the grievance and the date it was completed should be sent in a complaint resolution letter. See Complaint Job Aid_HCI, page 4.	
Findings: The *Grievance Policy*, *Complaint Delegation and Procedures*, and template complaint resolution letter accurately addressed the required content of grievance resolution notices. However, HSAG found one case in on-site record reviews in which the results of the grievance resolution in the complaint resolution letter did not address the member's stated complaint, thereby being *Not Met* for required content.		
Required Actions: HCI must develop a mechanism to ensure that the description of the grievance resolution in grievance resolution letters thoroughly addresses a member's stated complaint.		
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B2—None	**Evidence used:** 1. 305L_Appeal Policy_HCI, page 1 2. Appeal Guide_HCI, page 1 *Misc. 3. Appeal Decision Letter_HCI, pages 3-4 4. Provider Handbook2019_HCI, page 18 *Misc. 5. Appeal Job Aid_HCI, page 2 **Narrative:** Health Colorado has delegated behavioral health appeals to Beacon Health Options. Beacon has only one level of an appeal for the Member.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Beacon follows the 305 L Appeals Policy which states that there is only one level of an appeal for a Member. See 305L_Appeal Policy_HCI, page 1. Beacon follows an Appeal Job Aid_HCI which outlines the procedures for resolving Member appeals and states that there is only one level of appeal for members. See Appeal Job Aid_HCI, page 2 HCI has developed an appeal guide to educate Members that there is only one level of an appeal. See Appeal Guide_HCI, page 1. Beacon sends an appeal decision letter to a member after an appeal decision is made. The letter outlines the next steps Members can take if they are in disagreement with the appeal decision letter. The letter explains that Members can request a State Fair Hearing with the Administrative Law Judge. See Appeal Decision Letter_HCI, pages 3-4. Beacon developed and maintains a Provider Handbook2019_HCI which states that Members will have only one (1) level of appeal the regional organization. See Provider Handbook2019_HCI, page 18.	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* Contract: Exhibit B2—8.7.5.1 10 CCR 2505 10 8.209.4.B	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 1 A, 6 IV 2, 8Cb 2. Appeal Guide_HCI, page 2, 3*Misc. 3. NOABD_HCI, page 4 *Misc. 4. Appeal Not Processed_HCI, entire document 4. Provider Handbook2019_HCI, page 79 *Misc.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Narrative: Health Colorado allows Members, Legal Guardians, or a DCR to file an appeal with HCI within 60 calendar days from the date on the Notice of Adverse Benefit Determination Letter. HCI outlines the date that a Member can request an appeal in the Notice of Adverse Benefit Determination letter. This letter is a primary way that Members know that they can request and appeal and the time frame to request an appeal. See NOABD_HCI, page 4. Beacon follows the 305L_Appeal Policy_HCI which states that members can file an appeal within sixty (60) calendar days. See 305L Appeal Policy, pages 1, 6, and 8. When Beacon receives an appeal request, the Member Engagement Specialist will ascertain if the appeal was received within the 60 day time frame. Appeal Not Processed letter to the person who filed the complaint. See Appeal Not Processed_HCI, entire document. HCI developed an Appeal Guide which outlines that members have sixty (60) days to file a complaint. This guide can be found on HCI's website, www.healthcoloradorae.com. See Appeal Guide_HCI, page 2, 3. Beacon developed and maintains a Provider Handbook2019_HCI which explains that Members have sixty (60) calendar days to file an appeal. See Provider Handbook2019_HCI, page 79.	
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)*	Inform health plan on-site that proposed federal rule changes include: Eliminate the requirement that an oral appeal must be followed by a written, signed appeal (must continue to treat oral appeals the same as written appeals).	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B2—8.7.5.2 10 CCR 2505-10 8.209.4.F	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 1, IA, page 6 IV 2 2. Appeal Guide_HCI, pages 3, 4 *Misc. 3. NOABD_HCI, page 4 *Misc. 4. Appeal Request Letter_HCI, entire document 5. Appeal Job Aid_HCI, pages 2-3 **Narrative***:* Health Colorado allows Members to file an appeal either orally or in writing. The Member Engagement Specialist informs Members that any oral standard appeal request needs to be followed up with in writing. Members do not need to follow up in writing for an expedited appeal request, See Appeal Guide_HCI, Page 3 Beacon follows the 305L_Appeal Policy_HCI which states that a Member can request an appeal orally or in writing. The policy states that if a verbal request is made for a standard appeal, the member will need to follow up this appeal request in writing, however, members do not need to follow up in writing for an expedited appeal request. See 305L Appeals Policy, pages 1, 6. HCI educates Members that they can request an appeal orally or in writing through several avenues. HCI sends a Notice of Adverse Benefit Determination letter which states that Members can request an appeal orally or in writing. See NOABD_HCI, page 4. HCI developed an Appeal Guide which states that a Member can file an appeal orally or in writing. See Appeal Guide_HCI, page 4. This guide is located on HCI's website, www.healthcoloradorae.com.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's Member Engagement Specialist manages all of behavioral health appeals received from Members. The Member Engagement Specialist follows the Appeals Job Aid which states that any verbal request for an appeal needs to be followed up in writing. Part of the protocol is to educate the Member that HCI needs for the Member to follow up their verbal request in writing. See Appeals Job Aid_HCI, pages 2-3. When a Member requests an appeal verbally, we make attempts to obtain their signed request by sending an Appeal Request Letter_HCI with the appeal receipt letter. See Appeal Request Letter_HCI. The Member Engagement Specialist uses the Appeal Job Aid_HCI which states that an expedited verbal appeal request does not need to be followed up in writing and a verbal standard appeal request needs to be followed up with a written request. See Appeal Job Aid_HCI, pages 2-3.	
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B2—8.1, 8.7.2 10 CCR 2505-10 8.209. 4.D	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 3 II A, 7 #4, 12 #3 2. Appeal Guide_HCI, page 3 *Misc. 3. Appeal Receipt Letter_HCI, entire document 4. Grievance Appeal Report_HCI, page 12 5. Quick Appeal Denied Request_HCI, Entire Document 6. Appeal Job Aid_HCI, pages 3, 9-10 **Narrative**: The Member Engagement Specialist sends the Member a written acknowledgement of an appeal within two (2) working days of	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	receipt, unless the member or designated client representative requests an expedited resolution. For an example of the template letter HCI sends, please see Appeal Receipt Letter_HCI, entire document. HCI follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. HCI follows the 305L_Appeal Policy_HCI which states that we will send an acknowledgement letter within two (2) working days from the date that we receive the standard appeal request. See 305L_Appeal Policy_HCI, pages 3, 7, 12. The date the appeal is received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. Since appeals can be filed orally but must be followed with a written request for standard appeals, the date of first contact is the date that starts the "appeal clock." If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. The Member Engagement Specialist documents the appeal receipt date in Beacon's Connect System. The Member Engagement Specialist sends an Appeal Receipt Letter to the Member. See Appeal Receipt Letter_HCI, entire document. If a Member is requesting an expedited appeal, the Member Engagement Specialist will follow the Appeal Job Aid_HCI and review with the Medical Director. See Appeal Job Aid_HCI, pages 9-10. If the Medical Director denies the expedited appeal request, the Member Engagement Specialist will send a Quick Appeal Denied Request letter which explains that their appeal will be treated like a standard appeal and HCI will need to the request in writing. See Quick Appeal Denied Request_HCI, entire document.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed an Appeal Guide which states what the Member can expect from HCI when they file an appeal. HCI lists that the Member can expect to receive an Appeal Receipt letter within two (2) business days. See Appeal Guide_HCI, page 3, See Appeal Job id_HCI Pages 3, 9-10. HCI sends a quarterly report to HCPF which documents HCI's compliance with sending an appeal acknowledgement letter within two (2) workings days. See Grievance Appeal Report_HCI, page 12.	
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B2—8.7.6, 8.7.7, 8.7.11	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 1 IA, 6 IV 2, 7f 2. Appeal Guide_HCI, pages 3-4, 5 *Misc. 3. Appeal Receipt Letter_HCI, entire document **Narrative**: Health Colorado's appeal process provides for Members, Guardians, Designated Client Representatives, or the legal representative of a deceased member's estate to request an appeal verbally once they have been notified of an Adverse Benefit Determination. HCI follows state and federal regulations to ensure that Members/ Guardians/DCR's can exercise all of their rights in the appeal process and that members have all access to appropriate files, can present evidence to substantiate their appeal, and that oral inquiries will be treated as an appeal to establish the earliest filing date. HCI's Member Engagement Specialist explains all rights to the Member when they call to request an appeal. The Member	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10 CCR 2505-10 8.209. 4.F, 8.209.4.I	Engagement Specialist communicates to the Member/Guardian/DCR of the limited time frames in making an appeal decision. HCI follows state and federal regulations for acknowledging appeals and keeping within deadlines for appeals. HCI follows the 305L_Appeal Policy_HCI which outlines that verbal standard appeal requests are treated as appeals to establish the earliest filing date on pages 1 and 6. The policy outlines that expedited requests do not need to be followed up in writing on page 6. The policy outlines that members, their representative, or the legal representative of a deceased member's estate are parties of the appeal on page 7 See 305L_Appeal Policy_HCI, pages 1, 6, 7. The date the appeal is received sets the clock for the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. Since appeals can be filed orally, but must be followed with a written request for standard appeals, the date of first contact is the date that starts the "appeal clock." If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. The Member Engagement Specialist documents the appeal receipt date in Beacon's Connect System and sends out an appeal receipt letter. See Appeal Receipt Letter_HCI, entire document. HCI developed an Appeal Guide which outlines who can request an appeal on a Member's behalf. HCI lists that guardians, a designated client representative or a legal representative of a deceased person's estate can request an appeal. See Appeal Guide_HCI, page 5.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* Contract: Exhibit B2—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Evidence used**: 1. 305L Appeal Policy_HCI, pages 2G, 2H, page 7c 2. Appeal Guide_HCI, pages 4-5 *Misc. 3. NOABD_HCI, pages 3, 4 *Misc. 4. Appeal Job Aid_HCI, page 3 5. Appeal Receipt Letter_HCI, page 2 6. Example of Collecting Appeal Data_HCI, entire document 7. Appeal Decision Letter_HCI, page 2 **Narrative:** Health Colorado' appeal process ensures that the member has a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments when they request an appeal. HCI informs the member of the limited time available to receive this information, especially in the case of an expedited appeal request. HCI's appeal process also ensures that the member and his or her representative know what is in the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. If a Member requests these records, HCI provides this information free of charge and sufficiently in advance of the appeal resolution time frame. HCI follows Beacon's 305L_Appeal Policy_HCI which outlines the information we will obtain from the Member to take into consideration for the appeal as well as the information we will	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	provide to the Member upon request within a reasonable time frame of the appeal resolutions. See 305L_Appeal Policy_HCI pages 2 and 7. Members are made aware that they can provide additional information for their appeal as well as the limited time that they may have to provide this information in the Appeal Guide. Members are made aware that they can request their records used for the appeal in the appeal guide and appeal receipt letter. See Appeal Guide_HCI, pages 4-5 and Appeal Receipt Letter_HCI, entire document. The Appeal Guide is sent with the appeal receipt letter. The guide can also be found on the website at www.healthcoloradorae.com. Members are also informed that they can provide information for an appeal in the Notice of Adverse Benefit Determination letter and that they can request the records used in making the appeal. See NOABD_HCI, pages, 3, 4. The Member Engagement Specialist follows the Appeal Job Aid_HCI which has a check list to ensure that we communicate the limited time frame that members or their representatives have to provide any information which they would like considered for their appeal. See Appeal Job Aid_HCI, page 3. To demonstrate that HCI takes into account all comments, documents, records and other information submitted by the Member or their representative without regard if this information was submitted or considered in the initial adverse benefit determination, see Example of Collecting Appeal Data_HCI. HCI's Member Engagement specialist compiles all information received from Member/DCR into a secure shared drive. This information is sent to the Peer Advisor. See Example of Additional Info for Appeal_HCI. Also, in HCI's appeal results letter, there is standard wording to show what information was used in making the appeal decision. See Appeal Results Letter_HCI, page 2.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract: Exhibit B2—8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 5 F, 7 B, 10 #6 2. Appeal Guide_HCI, page 4 *Misc. 3. NOABD_HCI, page 5 *Misc. **Narrative**: Health Colorado maintains an expedited review process for appeals for when we determine or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life. HCI ensures that punitive action is not take against a provider who requests an expedited appeal or supports an appeal on a Member's behalf. HCI follows the 305L_Appeal Policy_HCI which highlights that the RAE maintains an expedited review process for appeals when the provider or RAE believe that a standard decision could jeopardize the Member's life on pages 5 and 7. On page 10, the policy outlines that we do not take punitive action against a provider acting on the Member's behalf, See 305L_Appeal Policy_HCI pages 5, 7, 10. HCI notifies members of their right or their designated representative's right to request an expedited appeal in the Notice of Adverse Benefit Determination Letter. The letter indicates that there is no punitive actions if their provider requests an expedited appeal on their behalf. See NOABD_HCI, page 5. This portion of the letter explains that the Members can request a quick appeal if they or their health care provider believe that waiting ten (10) business days for HCI to decide their appeal would put their health at risk.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed an Appeal Guide which informs Members who can request an appeal on their behalf and that they or their DCR can request an expedited appeal if they believe that waiting for a decision will be harmful to their health. See Appeal Guide_HCI, page 4.	
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* Contract: Exhibit B2—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 7-8 B 2. Appeal Guide_HCI, page 4 *Misc. 4. Quick Appeal Denied Request_HCI, entire document, 5. Appeal Job Aid_HCI, page 11 6. NOABD_HCI, page 5 *Misc. **Narrative**: Health Colorado has a protocol in place to transfer a Quick Appeal Denied Request into standard time frames. HCI's Member Engagement Specialist contacts the Member when there is a Quick Appeal Denied Request and explains the transfer to a standard time frame to make an appeal decision. Members are notified by letter when their request for an expedited appeal is denied. See Quick Appeal Denied Request _HCI, entire document. In this letter, we explain that we will transfer the appeal to the time from for standard resolutions and that they can file a grievance if they are in disagreement with the denial to expedite their appeal. Health Colorado has not had a Denied Expedited Request up to this date. A letter template has been developed; see Quick Appeal Denied Request_HCI, entire document.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI follows the 305L_Appeal Policy_HCI. The policy outlines that any Quick Appeal Denied Request will be transferred to standard appeal time frames. The policy also outlines the procedures to communicate the denied expedited request to the Member and the Member's right to file a grievance about the Quick Appeal Denied Request. See 305L_Appeal Policy_HCI, pages 7-8. HCI developed an Appeal Job Aid_HCI which outlines that the appeal will be transferred to the time frame of a standard resolution if an expedited request is denied. See Appeal Job Aid_HCI, page 11. HCI developed an Appeal Guide which outlines what happens when a request for an expedited appeal is denied. See Appeal Guide_HCI, page 4. The appeal guide can be found on our website, www.healthcoloradorae.com. HCI sends members a Notice of Adverse Benefit Determination letter whenever there is a denial of behavioral health services. The letter outlines that when there is a request for an expedited appeal and the expedited time frame request is denied, that the appeal decision will be transferred to the standard appeal time frame. The Member Engagement Specialist attempts to communicate verbally and will send a letter of this Quick Appeal Denied Request. The letter also states that a member can make a complaint if they are unhappy with the decision to deny an expedited request. See NOABD_HCI, page 5	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	Inform the health plan on-site that proposed federal rule changes include to eliminate the 18-point requirement for taglines on appeal resolution notices. (Reviewed in Member Information standard.) **Evidence used**: 1. 305L_Appeal Policy_HCI, pages 2 E, 10 F, 11G 2. Appeal Guide_HCI, pages 3 *Misc. 3. Provider Handbook2019_HCI, page 17 *Misc. 4. Appeal Receipt Letter_HCI, page 2 5. Appeal Decision Letter_HCI, entire document 6. Appeal Job Aid_HCI, pages 3, 11-13 7. R4_GrieveAppealQ4_FY18-19_HCI, entire document 8. 307L_Member Information Requirements_HCI, pages 1-3 *Misc. Health Colorado aims to make a decision on each appeal and provides notice to the Member of the resolution of their appeal as expeditiously as the Member's health condition requires. This resolution time frame is within ten (10) working days from the receipt of the appeal. There are times that HCI may need to extend this time frame at the Member's request or because HCI needs more time to resolve an appeal. The date the appeal is received establishes the clock for resolving the appeal. This could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The ten (10) working days is used to collect information to be used in the appeal decisions. HCI follows the 305_Appeals Policy which outlines that those making appeal decisions will attempt to resolve the appeal as	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	expeditiously as the member's health condition require or within the ten (10) working days of receipt of the appeal. The policy states that the written notification to the member must be in a format easily understood by the member. See 305L_Appeal Policy_HCI, pages 2, 10, 11. The Member Engagement Specialist follows the Appeal Job Aid_HCI which outlines the ten (10) business day time frame and standards to review the letter to ensure that it is easily understood. See Appeal Job Aid_HCI, page 3. HCI developed an Appeal Guide to educate Members on the timeframes to make an appeal decision. See Appeal Guide Guide_HCI, page 3. HCI also sends out an Appeal Receipt Letter which states the date that we hope to have an appeal decision. See Appeal Receipt Letter_HCI, page 2. HCI uses their 307L_Member Information Requirements_HCI to guide the content in the Appeal Decision Letter. The Appeal Decision Letter is written at an appropriate reading level and in a format to be easily understood by Members. The Appeal Job Aid_HCI outlines the process for the readability testing to ensure that the letter can be easily understood by the Member the decision letter needs to be sent to the supervisor for approval prior to sending out the letter to the Member. See 307L_Member Information Requirements, pages 1-3. See Appeal Job Aid_HCI, pages 11-13. HCI sends Members an Appeal Decision Letter within ten (10) working days of the member filing the appeal. See Appeal Decision Letter_HCI, entire document. HCI sends HCPF a quarterly report which documents HCI's compliance of sending out the appeal decision letter within ten	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(10) business days. See R4_GrieveAppealQ4_FY18-19_HCI, entire document. Beacon educates providers on the timeframes used for appeal decisions in the Provider Handbook2019_HCI. See Provider Handbook2019_HCI, page 17.	
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B2—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 4 #5, 7B, 10 #7, 10 F 1c 2. Appeal Guide_HCI, page 3*Misc. 3. Appeal Decision Letter_HCI, entire document 4. Appeal Job Aid_HCI, pages 2-3. **Narrative**: Health Colorado resolves each expedited appeal and provides written notification within seventy-two (72) hours of receipt of the expedited appeal. See Appeal Decision Letter_HCI, entire document. HCI's Member's Engagement specialist also makes reasonable efforts to notify the Member of the appeal resolutions. HCI follows the 305 L_Appeal Policy which outlines that expedited appeal requests will be resolved within seventy-two (72) hours after the RAE receives the appeal. The policy also states that the RAE will make reasonable efforts to provide oral notification of the expedited appeal resolution. See 305L_Appeal Policy_HCI, pages 4, 7, 10. HCI developed an Appeal Guide which list what Members can expect with they make an expedited appeal request. The guide	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	explains that HCI will make a decision within seventy-two (72) hours for an expedited appeal request. See Appeal Guide_HCI, page 3. The Member Engagement Specialist follows the Appeal Job Aid_HCI which outlines the processes for both approved and Quick Appeal Denied Requests. See Appeal Job Aid_HCI, pages 2-3.	
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* Contract: Exhibit B2—8.7.14.2, 8.7.14.2.4, 8.5.6 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 2 E, 2 F, 7 #3d, 9-10 #5 2. 303L_Grievance Policy_HCI, page 8 #15a-b 3. Appeal Guide_HCI, pages 3-4 *Misc. 4. Complaint Guide_HCI, page 3 5. Appeal Extension Letter_HCI, entire document 6. Complaint Extension Letter_HCI-entire document **Narrative**: Health Colorado can extend the time frames for resolution of grievances or appeals (both expedited and standard appeals) by up to 14 calendar days when a Member requests the extension or when HCI believes that there is a need for additional information and communicates how the delay in making a decision would be in the Member's best interest. HCI follows all state and federal guidelines for extending time frames for resolution of grievances and appeals (both expedited and standard appeals) by fourteen (14) calendar days. HCI follows the 303L_Grievance Policy_HCI which outlines that we can extend the time frame for the resolution of a grievance by up	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to 14 calendar days if the Member requests the extension or if there is a need for additional information and that the delay is in the Member's best interest. See 303L_Grievance Policy_HCI, page 8. HCI notifies the Member within 2 business days when there has been a request for an extension and attempts to contact the Member on the phone. HCI sends out a letter to the member to notify them of the need for additional time and explains why it is in their best interest. See Grievance Delay Letter_HCI, entire document. HCI follows the 305L_Appeal Policy_HCI which outlines the protocols we follow when either a Member requests an extension, or when the RAE believe it would be in the Member's best interest to have additional time to make a decision. We send the Member written notification when the time frame is extended. The policy states that we will include the reason for the extension, the date by which HCI will make a final determination, and the notification of Member's rights to file a grievance if the Member disagrees with the extension. See 305L_Appeal Policy_HCI, pages 2, 7, and 9-10. The Member Engagement Specialist will send notification to the Member within two (2) business days once it is ascertained that additional days are needed. See Appeal Extension Letter_HCI, entire document. In the body of the letter, we document why it is in the Member's best interest to delay the appeal. Please see Example of Standard Delay Letter_HCI for content that is embedded in the letter with the reason for filing extension as well as the right to file a grievance if there is a disagreement about the extension. Members are made aware of the ability to delay either a grievance or appeal by up to fourteen (14) calendar days in the Appeal Guide and Complaint Guide located on our website,	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	www.healthcoloradorae.com. See Complaint Guide_HCI, page 3. See Appeal Guide_HCI, pages 3-4. Members are also alerted about this ability to delay a grievance or appeal decision in the Notice Of Adverse Benefit Determination Letter_HCI on page 5, 6.	
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 2 F 1b, 10 #5bi 2. 303L_Grievance Policy_HCI, page 8 #15b-c 3. Complaint Guide_HCI, page 3 4. Appeal Guide_HCI, pages 3, 5 *Misc. 6. Complaint Extension Letter_HCI, entire document 7. Appeal Extension Letter_HCI, entire document **Narrative**: Health Colorado makes reasonable efforts to verbally notify the Member promptly if there is an extension in making a decision about an appeal or a grievance when it is not requested by the Member. HCI sends a letter within two (2) calendar days of when the decision was to be made and alerts the Member in this letter that they can file a grievance about the delay. HCI will attempt to expeditiously resolve the appeal as the Member's health condition requires and no longer the expiration of the extension date. HCI follows the 303L_Grievance Policy_HCI which outlines the procedures when a resolution time frame needs to be extended. This includes verbally notifying the member and sending a letter with information on how to file a grievance if the Member does not agree with the extension. See 303L_ Grievance Policy, page 8.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI follows the 305L_Appeal Policy_HCI which outlines the procedures when a resolution time frame needs to be extended for an appeal. This includes verbally notifying the member, sending a letter with information on the reason for the delay and how to file a grievance if the Member does not agree with the extension, and our intent to make a decision as expeditiously as the Member's health requires. See 305L_Appeal Policy_HCI, pages 2, 10. HCI notifies the Member within 2 calendar days when there has been a request for an extension for an appeal or grievance and attempts to contact the Member on the phone to communicate this information. HCI sends out letters to the member to notify them of the delay. See Complaint Extension Letter_HCI and Appeal Extension Letter_HCI. HCI developed a Complaint Guide and an Appeal Guide to educate Members on the reason there may be a delay in resolving their complaint or appeal. The guides state that HCI may extend the decision date by up to fourteen (14) calendar days. These guides can be found on HCI's website, www.healthcoloradorae.com. See Complaint Guide_HCI, page 3 and Appeal Guide_HCI, pages 3 and 5.	
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed.	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 11 G 1, 11 G3a-d 2. Appeal Guide_HCI, page 5 *Misc. 3. State Fair Hearing Guide_HCI, entire document 4. Appeal Decision Letter_HCI, pages 2, 3-4	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	5. Appeal Decision Letter Example_HCI, entire document **Narrative**: Health Colorado documents in the appeal decision letter the results of the resolution process and the date it was completed. The appeal decision letter includes Members' right and procedures to request a State Fair Hearing if an appeal decision is not resolved wholly in favor of the member. The appeal decision letter outlines that Members can request that previously authorized benefits continue while the hearing is pending, how to make this request and that the Member may be held liable for the cost of these services if the hearing decision upholds HCI's adverse benefit determination. See Appeal Decision Letter_HCI, pages 2, 3-4. HCI follows the 305L_Appeal Policy_HCI. The policy outlines that the written notice will include the date the appeal decision was made, how members can request a State Fair Hearing, how members can request for services to continue throughout the hearing, and the Member's responsibility for payment if the State Fair Hearing is not in the member's favor. See 305L_Appeal Policy_HCI, page 11. HCI developed an Appeal Guide to educate Members on their rights when an appeal decision is not wholly in the Member's favor. The guide states that Members can file a State Fair Hearing and lists the ways that HCI can assist the Member in filing a State Fair Hearing. The guide also informs Members that they can request for their previously authorized services to continue during the hearing process and the Member's financial responsibility if the hearing is not in their favor. HCI sends an Appeal Decision Letter and includes a State Fair Hearing Guide so that members know what to expect during a State Fair Hearing. See Appeal Guide_HCI, pages 5.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI also developed the State Fair Hearing which states that a Member can request a State Fair Hearing when their appeal was not in the Member's favor on page 1. The guide outlines that Members can request for the previously authorized services to continue during the hearing, what a Member can expected from HCI and the Members' financial responsibility for the services they received during the course of the hearing if the hearing results are not in their favor. See State Fair Hearing Guide_HCI, pages 2-3. See Appeal Decision Letter Example_HCI, entire document.	

Findings:
While internal policies and procedures accurately defined the content of the appeal resolution letter, the content of actual appeal resolution letters and the *SFH Guide* insert did not clearly outline procedures for how to request continued benefits during an SFH as follows:

- The appeal resolution letter informs the member of the right to request continued benefits during the SFH if continued benefits are requested in 10 days; however, the information did not clarify that the member must be the one to request continued benefits—i.e., cannot be the provider—or inform the member that continued benefits must be requested through Health Colorado. In addition, the information did not explain that a request for continued benefits during an SFH applies only if the member had also continued benefits during the appeal.
- The *SFH Guide* inserted into the appeal resolution letter informs the member that, to continue services during the SFH, the member must request that services continue, but does not tell the member how to make the request—i.e., to make the request to Health Colorado within 10 days of the adverse appeal resolution letter.
- The sample letter of an overturned appeal decision informed the member that he or she may request an SFH. A request for an SFH applies only to "appeals not resolved in favor of the member."

Required Actions:
HCI must clarify information in its appeal resolution letter and *SFH Guide* regarding how the member may request continued benefits during an SFH. HCI must also remove information regarding the member's right to request an SFH from its overturned appeal decision letters.

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B2—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 1 IC, 11 #4b 2. Appeal Guide_HCI, page 6 *Misc. 3. State Fair Hearing Guide_HCI, page 1 4. Appeal Decision Letter_HCI, pages 3,4 5. NOABD_HCI, page 6 *Misc. 6. Provider Handbook2019_HCI, pages 18*Misc. **Narrative**: Health Colorado allows Members to request a State Fair Hearing within 120 calendar days upon receipt of an adverse appeal determination or if HCI fails to meet the notice and timing requirements. If HCI does not meet the requirements the appeal rights will be determined to be exhausted. HCI follows the 305L_Appeal Policy_HCI which states that Members have 120 calendar days from the date on the Adverse Appeal Decision letter to request a State Fair Hearing. The policy outlines that the appeal process will have been considered exhausted if the regional organization does not follow the notice and timing requirements. If the appeal process has been exhausted, members call file a State Fair Hearing. See 305L_Appeal Policy_HCI, pages 1 and 11. HCI's Member Engagement Specialist sends the Member an appeal decision letter which outlines the time frame that a Member can request a State Fair Hearing in the event of an adverse determination. The Appeal Decision letter records the exact date that the Member must request a State Fair Hearing by – which is 120 calendar days from the date of the Appeal Decision Letter. See Appeal Decision Letter_HCI, pages 3-4.	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI developed an appeal guide which outlines that a member's appeal benefits will have been considered exhausted if HCI does not adhere to the timelines and processes and that members can file a state fair hearing if this happens. See Appeal Guide_HCI, page 6. HCI developed a State Fair Hearing Guide which indicates the time frame that members have to request a state fair hearing. The guide also explains that if HCI did not follow the appeal time frames, that the Member can request a state fair hearing before filing an appeal. See State Fair Hearing Guide_HCI, page 1. HCI sends members a notice of adverse benefit determination letter when there is a denial in behavioral health services. The letter explains that members have 120 calendar days to request a state fair hearing if the decision about their appeal is not in the member's favor. The letter also explains that if HCI does not meet the appeal deadlines, that members may request a state fair hearing without waiting for us to decide their appeal. See NOABD_HCI, page 6. Beacon developed and maintains the Provider Handbook2019_HCI which educates providers on the 120 calendar day time frame for Members to file a State Fair Hearing in the event of an adverse appeal decision. See Provider Handbook2019_HCI, page 18.	
Findings: HCI's *Appeal Policy* and member communications regarding appeal processes accurately defined the 120-day time frame for requesting an SFH. However, the *SFH Guide* also inaccurately stated, "If Health Colorado does not follow the appeal time frames, you may request an SFH *before you file an appeal*." (The member must first file an appeal with Health Colorado and thereafter, if Health Colorado does not meet the appeal time frames, the member may request an SFH.)		
Required Actions: HCI must correct its *SFH Guide* to remove the phrase "before you file an appeal" from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B2—8.7.15.3	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 7 #3f 2. State Fair Hearing Guide_HCI, page 2 3. Appeal Decision Letter_HCI, page 4 **Narrative**: Health Colorado has procedures in place to include HCI, the Member, the Member's representative, or the representative of a deceased member's estate at a State Fair Hearing. HCI follows the 305L Appeal Policy which outlines the parties that need to be included in a State Fair Hearing which include the member and their representative or the representative of a deceased member's estate. See 305L_Appeal Policy_HCI, page 7. HCI developed a State Fair Hearing Guide which outlines the parties that can participate in the State Fair Hearing which includes a representative from HCI, the Member or their designated representative or representative from the member's deceased estate. The Member Engagement Specialist sends this guide with the Appeal Results Letter. See State Fair Hearing Guide_HCI, page 2. See Appeal Results Letter_HCI, page 4.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider*	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 8 C a-f 2. Provider Handbook2019_HCI, pages 17 *Misc. 3. Appeal Guide_HCI, page 5 *Misc. 4. State Fair Hearing Guide_HCI, pages 2-3 5. NOABD_HCI, page 7 *Misc. **Narrative**: Health Colorado provides for continuation of benefits/services during an appeal or state fair hearing which may be pending if a Member requests for services to be continued within ten (10) days of receiving the Adverse Benefit Determination or the intended effective date of the Adverse Benefit Determination. The services need to be ordered by an authorized provider, services were previously authorized, the authorization end date has not expired and the Member needs to request an appeal within the required time frames. HCI follows the 305L Appeal Policy which outlines the requirements for Members to request a continuation in their services. The policy states the requirements HCI follows which allows continuation of benefits only under certain circumstances. The Member has to: 1) request continuation of service in a timely fashion -- within 10 days of HCI mailing the adverse benefit determination or the intended effective date of the proposed adverse benefit determination; 2) The appeal is regarding a termination, suspension, or reduction of a previously authorized course of treatment; 3) the services were ordered by an authorized provider ; 4) the original period covered by the original authorization has not expired; 5) and the Member requests an appeal timely. The policy also states that a	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract: Exhibit B2—8.7.13.1 10 CCR 2505-10 8.209.4.T	provider cannot request continuation of benefits on behalf of a Member. See 305L_Appeal Policy_HCI, page 8 C a-f. HCI sends Members a Notice of Adverse Benefit Determination Letter when there is a denied behavioral health service. The letters outlines the procedures Members need to follow if they would like to request for continuation of services during the appeal. See NOABD_HCI, page 7. HCI developed an Appeal Guide and a State Fair Hearing Guide which outlines all of these requirements for continuation of benefits to continue. These guides are mailed with the Appeal Receipt Letter or the Appeal Decision Letter and are also located on HCI's website. See Appeal Guide_HCI, page 5 and State Fair Hearing Guide_HCI, pages 2-3. Beacon has developed and maintains the Provider Handbook2019_HCI which documents the requirements for Members requesting a continuation of services during an appeal or State Fair Hearing. The handbook notes that a provider cannot request a continuation of services on a member's behalf. See Provider Handbook2019_HCI, pages 17.	

Findings:

The *Appeal Policy* and member communications accurately addressed the criteria regarding continuing benefits during an appeal. However, the *SFH Guide* for members similarly applied each of these criteria to continuing benefits during an SFH, which are not applicable in their entirety. While the language of the written federal regulation does not clearly differentiate between criteria applicable to appeals vs. criteria applicable to SFH, HSAG verbally clarified during on-site interviews the interpretation of the applicability of these criteria for continuing benefits during an SFH: Bullet #1—"timely filing for continuation of benefits" means the member must have continued benefits during the appeal and must again request continued benefits during an SFH within 10 days of receiving notice of an adverse *appeal resolution*. The intended effective date of the adverse benefit determination no longer applies. Bullet #4—"the original period covered by the original authorization has not expired" does not apply to continuing benefits during an SFH. Bullet #5—the member must request an SFH in accordance with required time frames (120 days from the adverse appeal decision). HSAG found that HCI's *SFH Guide* included the following inaccuracies:

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• "The time period for the authorized service must not be over yet" applies to continuing benefits during an appeal, but not to an SFH. • In two places in the *SFH Guide*, it accurately stated the member must request continued benefits during an SFH within 10 days of an adverse appeal decision, but also inaccurately stated the member must request an SFH within 10 days. (Per 42 CFR 438.408[f], the member may request an SFH within 120 days from the adverse appeal decision). Due to inaccuracies in the SFH information provided to members, HSAG scored four of four eligible appeal record reviews as *Not Met* for "resolution letter includes required content."		
Required Actions: HCI must clarify information in its *SFH Guide* to accurately represent the requirements for requesting continued benefits during an SFH.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B2—8.7.13.2 10 CCR 2505-10 8.209.4.U	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 8 Da-c 2. State Fair Hearing Guide_HCI, page 3 3. Provider Handbook2019_HCI, page 17 *Misc. **Narrative**: Health Colorado will continue or reinstate benefits during the appeal or state fair hearing unless certain conditions occur. The conditions are that the member withdraws the appeal or State Fair Hearing request, the Member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days of receipt of the Notice of Adverse Resolution, or a State Fair Hearing Officer issues a hearing decision which is adverse to the Member. HCI follows the 305L_Appeals Policy which states the requested service will continue unless member withdraws the appeal, ten (10) calendar days pass after the RAE mails the notice providing the resolution of the appeal upholding the original RAE termination, suspension, or reduction of services, unless the member, within a ten (10) calendar day time frame makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	decision is reached; or the State Fair Hearing Office issues a hearing decision adverse to the member. See 305L_Appeal Policy_HCI, page 8. HCI developed a State Fair Hearing Guide which outlines that HCI will continue or reinstate benefits unless certain conditions exist. See State Fair Hearing Guide_HCI, page 3. Beacon has developed and maintains a Provider Handbook2019_HCI which outlines that the regional organization will continue or reinstate Member benefits unless certain conditions occur. See Provider Handbook2019_HCI, pages 17.	
Findings: HCI's *Appeal Policy* accurately stated the criteria related to how long benefits will continue during an appeal. However, the *SFH Guide* for members similarly applied each of these criteria to how long benefits will continue during an SFH, which are not applicable in their entirety. HSAG provided on-site guidance that criteria Bullet #2 applies only to appeals, not to an SFH. If a member requests continued benefits during an SFH, benefits will continue until either: the member withdraws the request for an SFH or an SFH officer issues a hearing decision adverse to the member.		
Required Actions: HCI must revise its *SFH Guide* to remove the clause "you do not request an SFH and continued services within 10 days of an appeal decision not in your favor" from the description of how long benefits will continue during an SFH.		
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 8 D 1 2. Appeal Guide_HCI, page 5 *Misc. 3. State Fair Hearing Guide_HCI, page 3 4. Provider Handbook2019_HCI, page 17 *Misc.	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* Contract: Exhibit B2—8.7.13.3 10 CCR 2505-10 8.209.4.V	**Narrative**: Health Colorado may recover the cost of services provided to the Member while an appeal or State Fair Hearing was pending if the decision upholds the adverse benefit determination and the reason that the services were provided were based on the requirements in this section. HCI follows 305L_Appeal Policy_HCI which outlines that costs of services can be recovered by the RAE when services were provided to the Member during an appeal or State Fair Hearing and the appeal determination upholds the original decision to deny services to the extent that the services were furnished solely based on the requirements of this section. See 305L_Appeal Policy_HCI, page 8. HCI developed an Appeal Guide and a State Fair Hearing Guide which outlines that Members may be financially responsible to repay for any services that were provided during the appeal if the appeal decision was upheld by an external entity. See Appeal Guide_HCI, page 5 and State Fair Hearing Guide_HCI page 3. HCI developed and maintains the Provider Handbook2019_HCI which states If the RAE's decision on a member's appeal is adverse to the member, the RAE may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements of this section. See Provider Handbook2019_HCI, page 17.	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* Contract: Exhibit B2—8.7.13.4 10 CCR 2505-10 8.209.4.W	**Evidence used**: 1. 305L_Appeal Policy_HCI, pages 8-9 #2 2. Provider Handbook2019_HCI, page 17 *Misc. 3. Evidence of Authorization After Appeal_HCI, entire document 4. Evidence of Overturned Appeal Decision Letter_HCI, entire document **Narrative**: Health Colorado will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date HCI receives the notice reversing the adverse determination. HCI follows the 305L_Appeal Policy_HCI which outlines that the RAE will authorize or provide the disputed services promptly or as expeditiously as possible but no later than 72 hours from the date that we receive the notice reversing the adverse determination. See 305L_Appeal Policy_HCI, pages 8-9. HCI developed and maintains the Provider Handbook which outlines that the regional organization will authorize or provide the disputed services promptly or as expeditiously as possible but no later than 72 hours from the date that we receive the notice reversing the adverse determination. See Provider Handbook2019_HCI, page 17. HCI has submitted evidence of authorizing services which had been previously denied. A guardian had requested RTC services for her daughter which were denied. The peer reviewer overturned this	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	decision. See Evidence of Overturned Appeal Decision Letter_HCI, entire document. Beacon's care manager updated the authorization the authorization within 72 hours to reflect that these services would be covered. See Evidence of Authorization After Appeal_HCI, entire document.	
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* Contract: Exhibit B2—8.7.13.5 10 CCR 2505-10 8.209.4.X	**Evidence used**: 1. 305L_Appeal Policy_HCI, page 9 b 2. Provider Handbook2019_HCI, page 17 *Misc. 3. Evidence of Payment_HCI, entire document 4. Appeal Job Aid_HCI, page 13 **Narrative**: Health Colorado will pay for any disputed services a Member receives while the appeal was pending if HCI or the State Fair Hearing reverses the decision to deny authorization of services. HCI follows the 305L Appeal Policy which states that the regional organization will authorize and pay for disputed services while the appeal was pending if the regional organization or the State Fair Hearing officer reverses a decision to deny authorization of services. See 305L_Appeal Policy_HCI, page 9. HCI's Member Engagement Specialist follows the Appeal Job Aid_HCI which outlines procedures to be followed when an appeal decision is reversed. The Job Aid states that when we receive notification of a reversal of a decision, the Member Engagement Specialist will notify the clinical team to update the authorization	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and send to claims so that Beacon can pay the authorization. See Appeal Job Aid_HCI, page 13. Beacon has developed and maintains the Provider Handbook2019_HCI which states that the regional organization will pay for any disputed service that were provided while the appeal was pending and the decision was reversed by either the regional organization or the State Fair Hearing officer. See Provider Handbook2019_HCI, page 17. HCI has included an email chain reflecting that payment for services was made once an appeal had been overturned. See Evidence of Payment_HCI, entire document.	
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable.	**Documents Submitted:** 1. Feedback Database_HCI, entire document 2. 303L_Grievance Policy_HCI, page 9 C A1a-j, 9 C5 3. 305L_Appeal Policy_HCI, pages 12-13 Ka-f 4. Grievance and Appeal Excel Report_HCI, entire document. **Narrative**: HCI has delegated the maintenance of records related to grievances and appeals to Beacon Health Options. Beacon maintains records of all grievances and appeals in an accurate manner which is accessible to the State and available upon request to CMS. Beacon is responsible to submit a quarterly report to HCPF with a general description of the reason for each grievance or appeal, the date the appeal/grievance was received, reviewed and resolved, the name of	**HCI** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* Contract: Exhibit B2—8.9.1–8.9.1.6 10 CCR 2505-10 8.209.3.C	the person for whom the grievance/appeal was filed, the date of each review if applicable, and the resolution. HCI follows the 305L_Appeal Policy_HCI which has a section entitled Monitoring and Reporting by the Member Engagement Specialist. Each appeal is logged upon receipt and assigned expeditiously to an appropriate reviewer with notification to the reviewer of the timeline for a resolution. All required information is recorded and documented in Beacon's secure shared drive. See 305L_Appeal Policy_HCI, pages 12 and 13. HCI follows the 303L_Grievance Policy_HCI which outlines the necessary information that the Member Engagement Specialist or Advocate need to enter into the Feedback Database which includes the date the grievance is received, Member's name, description of grievance, date of and resolution at each level of review for the grievance (if applicable) and the date of grievance resolution. The policy states that the RAE will submit a quarterly report to the state with all of this information. See 303L_Grievance Policy_HCI, page 9. Beacon's Member Engagement Specialist is responsible to review the Feedback Database on a monthly basis to ensure fidelity to the collection of data. See Feedback Database_HCI, entire document. Beacon submits the Grievance and Appeal Report on a quarterly basis to HCPF. The report includes an excel spread sheet that separates out appeals and grievances. HCPF requires that we document the date the grievance or appeal is received, Member's name, the description of grievance or appeal, date of and resolution at each level of review for the grievance/appeal (if applicable) and	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the date of grievance/appeal resolution. See Grievance and Appeal Excel Report_HCI, entire document.	
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending,	**Evidence used**: 1. Provider Contract_HCI, pages 6, 9, 18, 27 2. Provider Handbook2019_HCI, pages 15 – 19 *Misc. **Narrative**: Health Colorado has delegated the provider network responsibilities to Beacon Health Options. Providers must sign a contract when they enter the Beacon network which serves Medicaid members. When providers sign the contract, they attest that they will follow the Provider Handbook2019_HCI which has all of the information about the grievance, appeal, and State Fair Hearing processes and systems. See Provider Contract, pages 6, 9, 18, 27. The information in the handbook includes the member's right to file a grievance or appeal, the requirements and time frames to file grievances and appeals, the Member's right to a State Fair Hearing when HCI makes a decision on an appeal which is adverse to the member, Beacon's availability to help Members with the filing process, the member's right to request continuation of services when certain requirements are met and that members may be required to pay for the cost of the service if the State Fair Hearing is adverse to the member. See Provider Handbook2019_HCI, pages 15-19.	**HCI** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B		
Findings: HCI's provider handbook (as referenced in the provider contract) described the detailed processes related to processing grievances and appeals. However, the provider handbook included inaccuracies in the circumstances and standards related to requesting continued benefits during an SFH (i.e., mimics the inaccuracies noted in element #29). In addition, HSAG noted that the provider handbook did not indicate *how* a member must request continued benefits (e.g., from Health Colorado) nor did it specify that a provider cannot request continued benefits on behalf of a member. HSAG recommends that HCI consider adding these clarifications to the provider handbook.		
Required Actions: HCI must revise the grievance and appeal information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH, as outlined in findings related to 42 CFR 438.420(a-b)—element #29 in this tool.		

Results for Standard VI—Grievances and Appeals							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	29
				Total Score ÷ Total Applicable		=	83%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Health Colorado, Inc. (Region 4)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 24, 2020
Reviewer:	Erika Bowman, BA, CPC—HSAG
Participating Plan Staff Member(s):	Dr. Steve Coen and Tiffany Jenkins

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	1/20/19	2/05/19	2/25/19	4/29/19	5/9/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	S	S	S
Date notice of adverse benefit determination (NABD) sent	1/22/19	2/05/19	2/27/19	4/29/19	5/9/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	2	0	2	0	0
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	NM	NM	NM
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Met Elements	**5**	**5**	**5**	**5**	**5**
Score (Number Met / Number Applicable) = %	**83%**	**83%**	**83%**	**83%**	**83%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 1: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 2: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 3: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 4: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 5: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Health Colorado, Inc. (Region 4)

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	7/7/19	7/30/19	8/29/19	11/14/19	12/20/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	S	S	S
Date notice of adverse benefit determination (NABD) sent	7/10/19	7/31/19	9/4/19	11/14/19	12/23/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	3	1	6	0	3
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (N or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM	M	M	NM
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Met Elements	**5**	**5**	**6**	**6**	**5**
Score (Number Met / Number Applicable) = %	**83%**	**83%**	**100%**	**100%**	**83%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 7: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria" and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

File 10: This was a new service request. HCI's NOABD incorporated language such as "exclusionary criteria," "emphasis," and "less restrictive setting" to describe the reason for the adverse benefit determination. The language content used in the NOABD sent to the member would not be easy to understand.

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Score:
	60	52	87%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Health Colorado, Inc. (Region 4)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 24, 2020
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member(s):	Lynne Bakalyan, Dawn Claycomb

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	1/18/19	M ☒ N ☐ N/A ☐	2/6/19	13w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) The grievance was not related to clinical care.										
2	****	2/8/19	M ☒ N ☐ N/A ☐	2/11/19	1w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (HCI processed) The grievance was not related to clinical services.										
3	****	2/28/19	M ☒ N ☐ N/A ☐	3/14/19	10w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) Mother complained about the provider not diagnosing correctly and sending her son to the emergency room (ER). The reviewer was able to see in the provider notes that the member did not perceive correctly the clinical reason her son was sent to the ER and did not refer the grievance to a clinical reviewer. The grievance resolution explanation did not address the mother's stated grievance.										
4	****	3/28/19	M ☒ N ☐ N/A ☐	4/8/19	7w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (HCI processed) The member had limited understanding of the English language, and misunderstood what the nurse was saying. The member perceived she was treated poorly by the nurse. The grievance was not related to clinical care. The grievance was adequately resolved.										
5	****	4/15/19	M ☒ N ☐ N/A ☐	4/26/19	9w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) The member was upset he was discharged from the primary care provider practice due to inappropriate behavior. Investigation revealed member had been warned multiple times about inappropriate behavior.										
6	****	5/2/19	M ☒ N ☐ N/A ☐	5/10/19	6w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) The grievance was not related to clinical care.										
7	****	6/14/19	M ☒ N ☐ N/A ☐	6/14/19	0w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (HCI processed) Both an acknowledgement letter and a resolution letter were sent on 6/14/19. The grievance was not related to clinical care.										
8	****	9/3/19	M ☒ N ☐ N/A ☐	9/24/19	15w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) The grievance was not related to clinical care. An extension letter was sent on 9/20/19 and the grievance was resolved on 9/24/19.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Health Colorado, Inc. (Region 4)

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
9	****	10/2/19	M ☒ N ☐ N/A ☐	10/11/19	7w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) The grievance was not related to clinical care.										
10	****	11/18/19	M ☐ N ☐ N/A ☒	11/19/19	1w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: (Delegated entity processed) The grievance was resolved in one day; therefore, no separate acknowledgement letter was required. The grievance was not related to clinical care.										
Do not score shaded columns below.										
		Column Subtotal of Applicable Elements	**9**			**10**	**10**	**2**	**10**	**10**
		Column Subtotal of Compliant (Met) Elements	**9**			**10**	**10**	**1**	**9**	**10**
		Percent Compliant (Divide Met by Applicable)	**100%**			**100%**	**100%**	**50%**	**90%**	**100%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**51**
Total Compliant (Met) Elements	**49**
Total Percent Compliant	**96%**

* Grievance timeline for resolution and notice sent is 15 working days.
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Health Colorado, Inc. (Region 4)

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 24, 2020
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member(s):	Lynne Bakalyan, Dawn Claycomb

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	2/20/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	3/5/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The appeal acknowledgement letter was sent in the required time frame and included the member appeals guide. This was a post-discharge retrospective appeal. Per HCI policy, retrospective appeals require a 30-day resolution time frame. The resolution letter was sent on 3/5/19. The resolution letter included the SFH information and the member *SFH Guide*. Both the acknowledgement letter and resolution letter were sent to the attention of the member's DCR and copied to the member. The SFH information in the resolution letter informed the member of the right to continue benefits during the SFH, although the member had not requested continued benefits during the appeal. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											
2	OMIT	3/18/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal concerned an administrative denial for one day of inpatient stay due to no authorization request submitted by the provider for that one day. HCI authorized days both preceding and subsequent to this one denied day based on authorization requests submitted. Because this was an administrative denial due to failure of the provider to obtain authorization, the member was not notified and the appeal was not processed due to the fact that provider administrative denials cannot be appealed (per HCI policy). Because this was not a member appeal and the appeal was not processed, the record was omitted from the sample.											
3	OMIT	5/3/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This was a verbal appeal from the parent of an adolescent. The appeal required a DCR form signed by the member. Prior to receiving the signed DCR form, the member was discharged and the verbal appeal was withdrawn. This record was omitted from the sample.											
4	OMIT	5/14/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the inpatient provider facility. The appeal was not processed by HCI as it was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
5	OMIT	6/6/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. There was no DCR form signed by the member. In addition, the appeal was a request for retrospective review of dates of hospitalization that were not originally denied, and the provider submitted the appeal outside of the required 60-day time frame from the NOABD regarding the dates that actually were denied. Whereas this appeal involved multiple procedural issues, it was not processed. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
6	OMIT	7/19/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 7/19/19 for services denied 5/20/19, exactly at the 60-day time frame for filing. There was no DCR form signed by the member. Although HCI verbally notified the provider of the need for a DCR form, none was received within the 60-day time frame. The appeal was not											

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
processed by HCI as it included no DCR form and was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
7	OMIT	8/26/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 8/26/19 for services denied 7/10/19, but there was no DCR form signed by the member. Although HCI verbally notified the provider of the need for a DCR form no later than 9/8/19 in order to be within the 60-day filing time frame, none was received. The appeal was not processed by HCI as it included no DCR form. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
8	****	10/15/19	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	10/16/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The appeal was requested by the Department of Human Services as the legal guardian for the member. The appeal was upheld due to "not a covered benefit of the health plan." The appeal was expedited. No acknowledgement was required. The appeal resolution letter was sent one day following receipt of the appeal and included SFH information. However, the SFH information informed the member of the right to continue benefits during the SFH, although the originally denied services had not been initiated. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											
9	OMIT	10/21/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 10/21/19 for services denied 6/8/19. The appeal was not processed by HCI as it was submitted outside the 60-day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
10	****	12/3/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☒ No ☐	12/26/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: The member appeal was received on 12/3/19. At the member's request, the appeal decision was extended on 12/12/19 to allow time for the member to obtain additional information. The appeal decision was completed on 12/26/19. The appeal resolution letter included the SFH information; however, the information informed the member of the right to continue benefits during the SFH, although the original denial did not pertain to previously authorized services and the member was not eligible for continued benefits during the appeal. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											
OS1	OMIT	2/5/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 2/5/19 for services denied 11/29/18. The appeal was not processed by HCI as there was no DCR form and the appeal was submitted outside the 60-calendar day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
OS2	OMIT	3/22/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 3/22/19 for services denied 11/13/18. The appeal was not processed by HCI as there was no DCR form and the appeal was submitted outside the 60-calendar day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Health Colorado, Inc. (Region 4)

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
OS3	****	6/28/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	7/1/19	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This appeal was filed by the member's DCR. The appeal was acknowledged on the date it was received. The resolution letter included the SFH information and the member *SFH Guide*. The SFH information in the resolution letter informed the member of the right to continue benefits during the SFH, although the member had not requested continued benefits during the appeal. In this situation, it is not appropriate to include the right to continue benefits in the appeal resolution letter.											
OS4	OMIT	10/4/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was filed on 10/4/19 for services denied 7/19/19. The appeal was not processed by HCI as it was submitted outside the 60-calendar day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
OS5	OMIT	12/27/19	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This appeal was filed by the member's inpatient provider. The appeal was not processed by HCI as there was no DCR form and the appeal was submitted outside the 60-calendar day required time frame for filing appeals. Claims not paid (and related appeals) due to reasons of procedural issues on the provider's part (regardless of the reason for denial at any previous level of review) are not member appeals and should be processed through HCI's provider dispute process. This record was omitted from the sample.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**3**	**4**	**4**				**4**	**4**	**4**
Column Subtotal of Compliant (Met) Elements			**3**	**4**	**4**				**4**	**0**	**4**
Percent Compliant (Divide Met by Applicable)			**100%**	**100%**	**100%**				**100%**	**0%**	**100%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**23**
Total Compliant (Met) Elements	**19**
Total Percent Compliant	**83%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal.

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **HCI**.

Table C-1—HSAG Reviewers and HCI and Department Participants

HSAG Review Team	Title
Kathy Bartilotta	Associate Director
Erika Bowman	Project Manager
Sarah Lambie	Project Manager II
HCI Participants	**Title**
Alma Mejorado	Director of Provider Relations, Beacon Health Options
Alyssa Rose	Assistant Vice President of Operations, Beacon Health Options
Cathy Michopoulos	Chief Executive Officer/Program Officer, Health Colorado, Inc.
Christine Andersen	Director of Integration, Beacon Health Options
D'Anne Goldstein	Administrative Assistant, Beacon Health Options
Dawn Claycomb	Community Outreach Specialist, Beacon Health Options
Dr. Lisa Clements	Senior Director of Integration, Beacon Health Options
Dr. Steve Coen	Peer Advisor Ph.D., Beacon Health Options
Erica Arnold-Miller	Director of Quality Management, Beacon Health Options
Jennifer Hale-Coulson	Director of Care Coordination, Beacon Health Options
Jeremy White	Quality Manager, Beacon Health Options
Julia Duffer	Director of Community Engagement, Health Colorado, Inc.
Karen Lumpkin	Senior Director of Regional Quality, Beacon Health Options
Kat Fitzgerald	Quality Management Specialist, Beacon Health Options
Lindsey Carnick	Crisis Services, Beacon Health Options
Lynne Bakalyan	Director of Member Services, Beacon Health Options
Randi Addington	Compliance/Contract Manager, Health Colorado, Inc.
Tiffany Jenkins	Manager of Clinical Services, Beacon Health Options
Tina McCrory	Chief Operations Officer, Health Colorado, Inc.
Department Observers	**Title**
Brooke Powers	ACC Program Specialist—HCPF
Russell Kennedy	Quality & Compliance Specialist—HCPF

Appendix D. Corrective Action Plan Template for FY 2019–2020

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for HCI

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* Contract: Exhibit B-2—8.6.1–8.6.1.4 10 CCR 2505-10 8.209.4.A.1	HCI policies and other submitted evidence demonstrated that template NOABDs used for UM denials were written in a language easy to understand and informed the member of availability of the letter in other languages and alternative formats. However, HSAG found eight of 10 denial record reviews were *Not Met* for "correspondence with the member was easy to understand." HCI's notice incorporated language such as "exclusionary criteria," "emphasis," and "less restrictive" to describe the reason for adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.	HCI must ensure that the NOABD in its entirety is written in language that is easy for a member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-2—9.5.1.8	HCI implemented a phone survey of a small sample of the behavioral health network to evaluate the availability and timeliness of RAE members scheduling appointments and obtaining care. The December 2019 survey results illustrated that all of the standards were met by four of the 12 providers surveyed. Of the eight providers that did not have access, four providers did not have appointment availability for new members and the other four providers were nonresponsive to HCI's outreach attempts.	HCI must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). HCI must also ensure implementation of CAPs for providers that are not in compliance with these access to care standards.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B2—8.1 10 CCR 2505-10 8.209.5.G	The *Grievance Policy*, *Complaint Delegation and Procedures*, and template complaint resolution letter accurately addressed the required content of grievance resolution notices. However, HSAG found one case in on-site record reviews in which the results of the grievance resolution in the complaint resolution letter did not address the member's stated complaint, thereby being *Not Met* for required content.	HCI must develop a mechanism to ensure that the description of the grievance resolution in grievance resolution letters thoroughly addresses a member's stated complaint.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* Contract: Exhibit B2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	The content of actual appeal resolution letters and the *SFH Guide* insert did not clearly outline procedures for how to request continued benefits during an SFH as follows: • The appeal resolution letter informs the member of the right to request continued benefits during the SFH if continued benefits are requested in 10 days; however, the information did not clarify that the member must be the one to request continued benefits—i.e., cannot be the provider—or inform the member that continued benefits must be requested through Health Colorado. In addition, the information did not explain that a request for continued benefits during an SFH applies only if the member had also continued benefits during the appeal. • The *SFH Guide* inserted into the appeal resolution letter informs the member that, to continue services during the SFH, the member must request that services continue, but does not tell the member how to make the request—i.e., to make the request to Health Colorado within 10 days of the adverse appeal resolution letter. • The sample letter of an overturned appeal decision informed the member that he or she may request an SFH. A request for an	HCI must clarify information in its appeal resolution letter and *SFH Guide* regarding how the member may request continued benefits during an SFH. HCI must also remove information regarding the member's right to request an SFH from its overturned appeal decision letters.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
	SFH applies only to "appeals not resolved in favor of the member."	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B2—8.7.15.1–8.7.15.2 10 CCR 2505-10 8.209.4.N and O	HCI's *Appeal Policy* and member communications regarding appeal processes accurately defined the 120-day time frame for requesting an SFH. However, the *SFH Guide* also inaccurately stated, "If Health Colorado does not follow the appeal time frames, you may request an SFH *before you file an appeal*." (The member must first file an appeal with Health Colorado and thereafter, if Health Colorado does not meet the appeal time frames, the member may request an SFH.)	HCI must correct its *SFH Guide* to remove the phrase "before you file an appeal" from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. * *This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services*	The *Appeal Policy* and member communications accurately addressed the criteria regarding continuing benefits during an appeal. However, the *SFH Guide* for members similarly applied each of these criteria to continuing benefits during an SFH, which are not applicable in their entirety. HSAG found that HCI's *SFH Guide* included the following inaccuracies: • The "time period for the authorized service must not be over yet" applies to continuing benefits during an appeal, but not to an SFH. • In two places in the *SFH Guide*, it accurately stated the member must request continued benefits during an SFH within 10 days of an adverse appeal decision, but also inaccurately stated the member must request an SFH within 10 days. (Per 42 CFR 438.408[f], the member may request an SFH within 120 days from the adverse appeal decision). Due to inaccuracies in the SFH information provided to members, HSAG scored four of four eligible appeal record reviews as *Not Met* for "resolution letter includes required content."	HCI must clarify information in its *SFH Guide* to accurately represent the requirements for requesting continued benefits during an SFH.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* Contract: Exhibit B2—8.7.13.1 10 CCR 2505-10 8.209.4.T		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* Contract: Exhibit B2—8.7.13.2 10 CCR 2505-10 8.209.4.U	HCI's *Appeal Policy* accurately stated the criteria related to how long benefits will continue during an appeal. However, the *SFH Guide* for members similarly applied each of these criteria to how long benefits will continue during an SFH, which are not applicable in their entirety. HSAG provided on-site guidance that criteria Bullet #2 applies only to appeals, not to an SFH. If a member requests continued benefits during an SFH, benefits will continue until either: the member withdraws the request for an SFH or an SFH officer issues a hearing decision adverse to the member.	HCI must revise its *SFH Guide* to remove the clause "you do not request an SFH and continued services within 10 days of an appeal decision not in your favor" from the description of how long benefits will continue during an SFH.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	HCI's provider handbook described the detailed processes related to processing grievances and appeals. However, the provider handbook included inaccuracies in the circumstances and standards related to requesting continued benefits during an SFH (i.e., mimics the inaccuracies noted in element #29).	HCI must revise the grievance and appeal information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH, as outlined in findings related to 42 CFR 438.420(a-b)—element #29 in the compliance monitoring tool.

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* Contract: Exhibit B2—8.4 10 CCR 2505-10 8.209.3.B		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The RAEs also submitted lists of denials of authorization of services (denials), grievances, and appeals that occurred between January 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the RAE's key staff members to obtain a complete picture of the RAE's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG reviewed a sample of administrative records to evaluate denials, grievances, and appeals. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with RAE staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2019–2020 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the RAE and the Department for review and comment. • HSAG incorporated the RAE's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the RAE and the Department.

Appendix F. Focus Topic Discussion

Overview of FY 2019–2020 Focus Topic Discussion

For the FY 2019–2020 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Region-specific Initiatives Related to the Health Neighborhood.* Focus topic interviews were designed to obtain a better understanding of the infrastructure and strategies the RAEs have implemented/are implementing to actively build, support, and monitor Health Neighborhood providers, particularly those serving members with complex health needs ("impactable populations"). HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the FY 2019–2020 RAE Aggregate Report to determine and document statewide trends related to RAE region-specific activities to integrate with and build Health Neighborhoods. This section of the report contains a summary of the focus topic discussion for **HCI**.

Infrastructure and Strategies

HCI has historically aligned with a collection of different providers and community partners in the region over an extensive period of time. Staff members explained that **HCI** has a unique structure in which all delegated accountable care coordination entities—FQHCs and CMHCs—are involved in **HCI**'s Board of Directors and also conduct community-based work with a variety of provider organizations. The Board of Directors provides the strategic direction for Health Neighborhood activities. **HCI** initially chose not to initiate new Health Neighborhood initiatives but rather to survey the region to determine collaborations that already existed and approach those organizations to determine how the RAE can contribute. In addition, existing Health Neighborhood collaboratives overlapped with many agencies and provided a conduit for the RAE to develop relationships with additional agencies. Many of the existing collaborative initiatives were focused in the Pueblo service area, where most of the region's healthcare resources are concentrated. **HCI** provided several examples of its participation in existing Health Neighborhood initiatives:

- The RAE is a mandated partner in Interagency Oversight Groups (IOGs) targeting at-risk youth involved in multiple systems of services. **HCI** and the IOGs are examining the overlap in IOG and RAE performance measures, such as mental health measures and Key Performance Indicators (KPIs), and sharing data to benefit both organizations. For example, while the RAE can share Medicaid member well-child data, the IOG may be able to provide data concerning child physicals provided at public health facilities. Challenges and opportunities encountered to date include:
  - IOGs serve the broad population, while RAEs serve only Medicaid, creating a gap in what the RAE can provide to IOGs.
  - While RAE KPIs are specifically defined, IOG data are very broad and IOGs lack sophisticated data collection systems.

  - The RAE can use the IOG platform to educate agencies about the RAE and population health initiatives.
  - Because the RAE care coordination entities functioned previously as a component of the behavioral health organization (BHO), care coordinators had pre-established relationships with child welfare programs and function to wraparound services for members being served in multiple locations. The possibility of sharing care coordinators between the RAE and Department of Human Services (DHS) locations is under discussion. Staff members stated that the DHS structure in the region is complex and that the statewide child welfare forum, which engages DHS and the Department in discussions, is essential in facilitating regional efforts.

- Directing Others To Services (DOTS) is a program of the Pueblo Fire Department paramedics intended to divert community members from unnecessarily accessing emergency department (ED) services. Members with mental health needs experience a higher incidence of hospital readmission, ED use, and morbidity. Therefore, Health Solutions has collaborated with DOTS to integrate behavioral health care coordinators into the DOTS team, noting that members contacted at their home are much more receptive when the behavioral health (BH) coordinators are a part of the team. DOTS has been engaged as a partner in several regional collaborative initiatives.
- **HCI** participates in the Southeast Colorado Transitions Consortium (the Consortium). In operation since 2005, the Consortium objectives align with the Colorado Opportunity Project framework to remove barriers associated with coordinating care between hospitals and other levels of care. Hospital discharge planners work with **HCI** care coordinators to develop and facilitate an effective 30-day post-discharge plan for members. Participants include Parkview and St. Mary Corwin hospitals, **HCI**, and long-term care service providers. The Consortium engaged the DOTS team to assist in reducing hospital readmissions and ED utilization by recently discharged members. In 2019, the DOTS team tracking data indicated that the higher the number of social determinants—food, housing, and transportation—with which a patient struggles tends to correlate with a higher readmission rate. The Consortium has initiated development of a communication platform to document the community services in which an individual is engaged and which can be securely accessed by DOTS and all applicable provider and community organizations. At the time of on-site review, the RAE reported that the community service platform was in a trial testing phase between Health Solutions and Parkview Hospital (Parkview). The Consortium was also in the process of exploring food resources within the community.
- The Palliative Care Coalition (the Coalition) is focused on interventions to address gaps in transitions of care from inpatient palliative care to external palliative care services and reduce readmissions and morbidity of persons receiving palliative care services. The Coalition is comprised of Parkview, DOTS, **HCI**, Kaiser, Frontier Integrated Care Solutions, Rocky Mountain Cancer Center, several palliative care provider organizations, and select senior living facilities. **HCI** reported that the Coalition has grown as agencies have increased services to include palliative care. **HCI** provided diagnosis-specific data on frequency of hospitalizations of members who have diagnoses that might benefit from palliative care services—i.e., the RAE's "impactable populations." To that end, the Coalition recently expanded its goals to broaden the definition and application of palliative care services to include individuals with high-risk chronic conditions who need supportive services and to develop a plan to increase community awareness of palliative care services. The Coalition is developing mechanisms to overcome challenges in implementation, which include:

  - Educating members and providers to overcome the stigma that palliative care is synonymous with hospice care.
  - Expanding physician referrals to the program.

  The role of the palliative care agencies is to educate the community; the RAE's role is to educate primary care providers, contribute Medicaid member data, and offer care coordination resources; Parkview's role is to educate medical residents and hospital-based providers.

- Staff members noted that common challenges in aligning collaborative Health Neighborhood initiatives with RAE-specific goals and measures include:
  - The RAE represents one of many equal participants in Health Neighborhood initiatives. Medicaid members are only one faction of broader populations being addressed through regional collaborative initiatives. The collective objectives of each collaborative organization drive the initiatives, with the RAE contributing resources when available and applicable.
  - Outcome measures are similarly driven by the goals of each collaborative initiative. Most collaboratives track data related to specific interventions. Outcome measures of Health Neighborhood initiatives do not always align with RAE measures. In addition, data from multiple sources vary in definition, are often difficult to obtain, and are difficult to merge.

Improving Access to Specialist Providers

HCI reported that Region 4 experiences a significant shortage of all specialists in its rural and frontier geographic areas. **HCI** reported that Region 4 has no endocrinologists available in the entire region. Most specialists in the region are concentrated in and associated with hospitals in the Pueblo area. Primary Care Medical Provider (PCMP) practices in the Pueblo area have easier access to the specialists in their vicinity and refer more patients to specialists than PCMPs in outlying regions. PCMP referrals to specialists are based on long-standing relationships between the primary care and specialist providers. PCMPs are unwilling to disrupt their preferred specialist referral patterns through any mechanisms that formalize their relationships with specialists (e.g., provider referral contracts). Similarly, specialists are unwilling to engage in Medicaid referral agreements for fear that that they may be overwhelmed with an increase in Medicaid members. Region 4 members also access select medical specialists in the Denver metropolitan area, and Denver-based specialists are taking on members from all RAEs throughout the State, creating competition for limited access for Medicaid members. Children's Hospital Colorado (Children's) has opened a new location in Colorado Springs, which also experiences competition from multiple RAEs. To that end, **HCI** has established a "good partner" relationship with Children's for management of complex members, working through single points of contact for care coordination and referral communications. Staff members stated that, with the exception of select specialty services, most members are referred to specialists within the region; however, wait times for appointments are lengthy.

Stimulated by the need to meet the new Department deliverable to implement condition management protocols for its impactable populations, **HCI** recently conducted a direct survey (using Survey Monkey) with its PCMPs to determine which specialists in the region accept Medicaid members. Survey questions included what protocols PCMPs have in their practices and what specific specialists are used

by the PCMPs to manage the care of designated "condition management" populations. Staff members conducted follow-up outreach calls to practices to improve the response rate to the survey—reported to be approximately 45 percent. **HCI** would like to explore with the Department the potential for predictive analytics based on the Department's PCMP and specialist claims database to identify referral patterns between PCMPs and specialists that can be focused on members with chronic conditions. **HCI** could then conduct outreach to providers that align with **HCI**'s chronic care condition management goals. **HCI** acknowledged that, since Medicaid does not require referral or authorization to see a specialist, data analytics regarding referral pathways to specialists may have limited reliability. In addition, **HCI** would like to understand which specialists exist in the region that do not take Medicaid members. **HCI** is challenged with how to alter established referral patterns or increase the limited number of specialists available to Medicaid members in the region. **HCI** suggested that HCPF might work with hospitals on strategies to contract with additional specialists in the region. **HCI** is also considering the possibility of working with hospitals that provide chronic care specialty services to commercially insured members to expand access to Medicaid members. **HCI** reported that some hospital-aligned medical groups are hiring specialists to work within primary care practices. Staff members stated that it is too early to have measurable results of any initiatives to improve overall access to specialists.

Related to expanding access to psychiatric specialist services, **HCI** has engaged Colorado Psychiatric Access and Consultation (C-PAC) to provide "Doc-to-Doc" consultation to PCMPs throughout the region. C-PAC enables an increased number of members to receive behavioral health services at the primary care level, with referral of higher need members to **HCI** care managers to manage referrals to the region's limited psychiatric resources. **HCI** has identified psychiatrists willing to take Medicaid members, although wait times for appointments may be long. Care coordinators work with members to arrange services to maintain stability of the member pending appointment availability. Measurable results include an increase in utilization of C-PAC services, and an increase in providers retaining behavioral health members at the primary care practice level. This program has experienced more success in frontier and rural areas, where providers are willing to make use of any resources available in caring for their members. Measures related to the impact on member outcomes would necessarily be long term.

To gain the perspectives of specialists related to issues with Medicaid patients that result in limited access for Medicaid members, **HCI** had previously obtained input from county medical societies which identified no-shows and limited payment as the major issues. Working through its care coordinator relationships with PCMPs, **HCI** care coordination entities throughout the region work with PCMPs to prospectively identify members with specialty care needs and assist members with arranging appointments and organizing transportation services to specialist appointments both in and out of the region. Care coordinators also follow up with members after specialist visits to reconnect them to the PCMP. Staff members noted, however, that many high-cost members do not choose to engage in care coordination services. To educate the general member population, **HCI** includes in its "lunch and learn" member meetings—held in communities throughout the region—information pertaining to the importance of keeping appointments and member responsibilities. Behavioral health peer specialists also will remind members of appointments or will attend a specialty appointment with a member if the member wants them to do so.

Collaborative Initiatives with Hospitals

HCI has met with 14 hospital conglomerates throughout the region involved in the Hospital Transformation Program (HTP). **HCI** provided an initial presentation to each organization to introduce the RAE and suggest how the hospital(s) and RAE might work together to support their individual HTP initiatives, including review of RAE measures that might align with the HTP measures and reviewing RAE reports that can be accessed online. At the time of on-site review, **HCI** reported that most hospitals had completed their HTP community needs assessment, determined priority initiatives, and selected their performance measures. Alignment of HTP measures with the RAE and other agencies was an important consideration of all HTP organizations. In those HTP groups in which the RAE is actively involved, the RAE provides data to support initiatives and is participating in planning and implementation of initiatives. **HCI** has identified to each HTP workgroup that the RAE has a high level of interest in obtaining information on members discharged to specialty care; however, this RAE objective does not always align with each community's HTP priorities. Each of the HTP consortium groups in the region involves a wide combination of Health Neighborhood stakeholders. Although each group is actively engaged in varying collaborative initiatives in which the RAE may not be actively involved, each organization individually reaches out to the RAE to examine possible workflows and data-sharing arrangements to meet the HTP objectives. The RAE has offered **HCI**'s performance improvement advisory council (PIAC) meetings as a vehicle for maintaining an ongoing relationship between hospitals and the RAE. RAE performance measures and some of the HTP measures have been aligned when applicable. **HCI** stated the HTP has forced much-needed collaboration among hospitals, community stakeholders, and the RAE. **HCI** described the following examples of RAE collaboration in HTP initiatives:

- Centura Health (Centura) has two hospitals in Region 4. Centura and the RAE identified that screening for social determinants of health and providing screenings to **HCI** care coordinators matched both organizations' objectives. The RAE identified the need for increased access to specialty care, which to date has not been fully explored. Centura identified that it lacks information to know whether its patients connect to services included in each member's discharge plan. Centura and **HCI** have been developing collaborative discharge planning objectives which focus on: collaborative discharge planning for members with substance use disorder or mental health needs, developing protocols that address the three most common "condition management" diagnoses and connecting those members to primary care following discharge, and referring postnatal members to the RAE for monitoring postpartum depression. In addition, the Centura/RAE collaborative team will explore sharing readmission and discharge measures and how to share social determinants of health. Through the health information exchange, Centura is notifying the RAE of admissions, discharges, and transfers data, which could possibly be modified to include additional elements. Centura will continue its work with the RAE before finalizing its choices of initiatives; however, activities have been delayed due to coronavirus disease 2019 (COVID-19).
- The RAE initiated meetings with the Parkview hospital network (four hospitals). Health Solutions representatives attend all HTP meetings. The Parkview hospital network intends to develop a unified approach for all facilities and is interested in the resources that the RAE can provide to support the HTP goals.

- The RAE provided consultation to the Western Healthcare Alliance (affiliated hospital in Kiowa) regarding analysis of the community needs assessment, which indicated a high level of dental needs in the community. The RAE will continue to work with the hospital to determine how to address dental needs and develop measures.
- The RAE worked with Heart of Rockies in Salida to identify possible HTP performance measures.

At the time of on-site review, **HCI** reported that progress on many of the HTP initiatives has been delayed due to COVID-19 concerns.

HCI described additional hospital collaborative projects aligned with the RAE's potentially avoidable costs (PAC) plan.

- Parkview is leading initiatives related to improving transitions of care for maternity and diabetic patients. Related to maternity patients, the collaborative noted difficulty in identifying members to the hospital early in their pregnancies. Parkview has provided insights into what the hospital is doing to facilitate this effort; the RAE will develop mechanisms to involve the Medicaid provider network in this initiative. Parkview and the RAE also identified a specific initiative to address shared interest in decreasing the high premature birth rate in the region. Parkview identified that an increasing number of babies are being born with opioid addiction and a barrier to improvement is that pregnant women addicted to opioids avoid seeking prenatal care. Such an initiative will engage many other Health Neighborhood partners such as the Pueblo Nurse-Family Partnership and the Friendly Harbor Community Center and will require funding to support interventions.
- San Luis Valley Regional Medical Center—an integrated hospital, medical clinic, and mental health center system in Alamosa—is piloting a diabetes registry in its hospital and medical clinic. The RAE participated in identifying the key pieces of data needed for the registry. The pilot program has been challenged by the difficulty of obtaining current data on members. **HCI** also maintains ongoing discussions with San Luis Valley concerning identifying and engaging high-risk pregnant women.

Other Health Neighborhood Initiatives

While **HCI** has, to date, participated in many established Health Neighborhood initiatives, **HCI** is formulating a strategy to initiate RAE-driven initiatives and refocus efforts to engage Health Neighborhood partners to address impactable populations. **HCI** is using its monthly PIAC meetings and associated Population Health Subcommittee to establish strategic initiative priorities that align with **HCI**'s objectives. To stimulate and support such initiatives, **HCI** has established a community reinvestment group to extend funding to eligible community or provider organizations in rural communities, and through which RAE staff resources may be offered. **HCI** identified several initiatives with Health Neighborhood partners to address impactable populations:

- **HCI** recently collaborated with Project Angel Heart on a project to prevent hospitalization of members with chronic obstructive pulmonary disease (COPD), hypertension, and/or diabetes—identified as high utilizers in RAE data—by providing medically-tailored meals to select members.

HCI will provide members with diabetic education courses and 30 days of free meals. **HCI** will also develop a data tracking mechanism to enable measurement of member outcomes.

- **HCI** identified a community reinvestment project to collaborate with the Pueblo County Department of Public Health and Environment (health department) to obtain grant funding to support provision of telehealth services for management of Type I diabetes. The collaborative involves schools, which have the capability to implement telehealth services and engage appropriate members in diabetic management services.
- **HCI** is working with the Southeast Area Education Center—one of two Area Health Education Centers (AHECs) in the region—to develop and provide tools to rural communities to facilitate self-management of chronic health conditions. The collaborative is evaluating different avenues available for providing education resources and is leaning toward digital mechanisms to most conveniently and widely engage members of the community.
- To address the RAE KPI—"Behavioral health screening or assessment for foster care children within 30 days of enrollment"—**HCI** has engaged with county DHSs to develop mechanisms to identify foster care children for follow-up by RAE care coordinators to engage the member in behavioral health assessment. Once members can be identified to the RAE, it is **HCI**'s intent to additionally analyze each member's alignment with other impactable or complex member populations. While the RAE and DHSs mutually agree on the need for BH services for many foster care children, this project has encountered numerous challenges and barriers to implementation, including:
  - The Department provides codes to DHS to denote children enrolled in foster care, and the Department provides the RAE with these codes to engage with foster care members. Staff members stated that the data provided by the Department to the RAE are "wildly" inaccurate and do not coincide with DHS data. For example, when **HCI** care coordinators contact members identified with the "new foster care aid" code, they are finding that the member is not a new foster care enrollee. In addition, further investigation of the data revealed that enrollment data are being backdated, thereby causing **HCI** to miss the 30-day time frame for assessment. The Department and DHS are working together to determine why data that goes from DHS through the Department to the RAE are inaccurate. **HCI** has requested that the RAE be added as a partner to the region-wide DHS Director's meetings to discuss measures needed by the RAE as well as how the RAE might assist DHS with measures. DHSs cannot provide the RAE with direct access to their databases, although Pueblo County DHS has developed a direct communication link with Health Solutions.
  - Smaller county DHSs do not have the technical capabilities to enable data exchange.
  - Some counties have resisted being involved in this initiative because the RAE priority does not align with the county's priorities. Some counties have identified the need to have a focus on adults in protective services rather than foster children.

All of these initiatives remain in a preliminary stage of development and measurement of outcomes is premature.

What the Department Can Do

HCI recommends that the Department work with DHS at the State level to explore mechanisms for providing RAEs direct access to DHS data, enabling the RAEs and county DHSs to work more effectively at the county level.

Related to increasing access to specialists, **HCI** recommends that the Department provide fee-for-service (FFS) specialist utilization data to be used in identifying referral patterns within RAE regions and that the Department conduct a full environmental survey of specialists who are accepting and not accepting Medicaid patients. **HCI** also recommends that the RAEs and the Department work collaboratively to explore creative solutions to increase specialist contracting and that the Department consider whether financial incentives might be offered for specialists accepting Medicaid members.

HCI stated that RAEs are experiencing a constantly shifting focus from the Department and evolving from very broad to very specific objectives and measures. **HCI** recommends that the Department allow adequate time for the RAE to adjust their priorities, engagement with partners, and other operations to respond to changes.

HCI recommends that the Department consider enhancing communications with providers to reinforce how participation in Health Neighborhood initiatives helps improve overall care for members, to stimulate providers to participate, and to provide some special designation from the State to recognize providers who do participate in Health Neighborhood collaboratives.