COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 Site Review Report

for

Health Colorado, Inc.

Region 4

June 2021

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 Proposal 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers (PCPs) and capitated behavioral health (BH) 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) 2020–2021 site review activities for **Health Colorado, Inc. (HCI**). For each of the four 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 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 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 credentialing and recredentialing 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 (CAP) process that the RAE will be required to complete for FY 2020–2021 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) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

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)
VII. Provider Participation and Program Integrity	16	16	15	1	0	0	94%
VIII. Credentialing and Recredentialing	32	31	29	2	0	1	94%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
X. Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**68**	**64**	**4**	**0**	**1**	**94%**

*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 credentialing and recredentialing 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)
Credentialing	50	40	40	0	10	100%
Recredentialing	45	35	35	0	10	100%
Totals	**95**	**75**	**75**	**0**	**20**	**100%**

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

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

HCI delegated provider recruiting, selection and retention activities, and day-to-day program integrity activities to Beacon Health Options (Beacon). **HCI** submitted comprehensive policies, procedures, supporting sample reports, and other documents that demonstrated alignment with State and federal requirements related to provider participation and program integrity. The provider relations and network management activities were informed by regular data analysis of the provider network, claims, and utilization. **HCI** developed an annual network adequacy plan, which was cited as a key driver for ongoing activities such as recruitment and engagement; ongoing efforts were assessed through quarterly and monthly reporting.

The *Network Development* document detailed how **HCI** created, administered, and maintained a network of BH providers to meet the needs of **HCI** members. The network included contracts with community mental health centers (CMHCs), federally qualified health centers (FQHCs), school-based health centers, regional health centers (RHCs), community safety-net clinics, adult and pediatric mental health and psychiatry, substance use disorder (SUD) providers, and psychiatric prescribers. SUD providers were a major focus of recruitment throughout 2020 in preparation for the SUD benefit expansion. Additionally, **HCI** leveraged self-service tools, trainings, and roundtable meetings to retain providers. The roundtables provided a venue through which providers could interact with **HCI** and also engage with each other to learn about best practices.

HCI's compliance plan included a multi-level committee structure, with ultimate responsibility residing with the board of directors. The compliance oversight committee included executive management, the compliance officer, and compliance staff members from **HCI** and Beacon. Policies and procedures included prevention, detection, investigation, and reporting/resolution functions for suspected fraud, waste, or abuse and conformed with federal and State regulations. Staff members within the compliance department were broken into roles by specialty, such as privacy, investigation, training, and audit staff members. **HCI** used Cornerstone software to ensure training for **HCI** staff members, and Beacon staff members were trained through the Relias system. The compliance team also engaged in ongoing educational activities such as annual conferences, obtaining certifications, and recent focuses on Lean Six Sigma activities.

The compliance department maintained effective lines of communication for staff members to report any suspected fraud, waste, or abuse issues. Reporting methods included a hotline, website, and mail. **HCI**'s program integrity monitoring included reports on member prescriptions, card sharing instances, general claim oversight, overpayments (upcoding, unbundling, services not rendered, inflated billing, improper payments), and other compliance risks as identified. Supporting documents outlined the various desk reviews and on-site audits that were conducted. Findings were reported to the Department and through other means as required and, when deemed necessary, provider payments would be suspended. The *Member Services Verification* plan was used to detect and deter fraud, waste, and abuse through sampling member services to validate whether or not they had been received.

Summary of Findings Resulting in Opportunities for Improvement

Staff members stated that **HCI** staff members were expected to report any suspicion of fraud, waste, or abuse immediately. While some examples, including an email reminder from the chief executive officer, did prompt employees to report issues immediately, the instruction regarding immediate reporting was not consistently emphasized throughout the compliance documents. Page 9 of the *Compliance Plan* document noted that "employees, providers, and contractors are required to report….within three busines days." Additional evidence, including the general compliance Microsoft PowerPoint slides, did not include time frame expectations for employees to report suspected issues. While the regulations do not specify an exact timeline, and either three days or immediately would meet this requirement, HSAG recommends updating the *Compliance Plan* and other supporting documents to ensure the expectation to report immediately is consistently communicated to employees, providers, and contractors.

While page 40 of the BH provider manual stated that providers may not balance bill members or seek reimbursement, deposits, etc., the section also mentions possible "member expenses." However, within the RAE structure, there are no copays for BH services. HSAG recommends that **HCI** either remove the reference to expenses or further clarify what, if any, specific instances the member may be liable for services. Additionally, there were no details regarding member liability within the PH provider manual, and the PCP provider agreement included one general statement that providers agree to bill "in accordance with the rules and regulations of Health First Colorado." HSAG recommends within the PCP provider agreement that **HCI** further clarify when applicable copays and other member costs may be applicable.

Summary of Required Actions

Although **HCI** reported that the organization does not have any moral or religious objections to services, neither the BH provider manual nor the PH provider manual included language to confirm this approach. **HCI** must update informational materials to clarify that, while an individual provider may have such objections, **HCI** as an organization does not. Furthermore, **HCI** should provide additional information stating that, if the provider objects to services, the member should be referred back to **HCI** to be assigned to a different provider if needed.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

HCI's established policies, procedures, and supporting documents demonstrated adequate systems to ensure that all credentialing and recredentialing requirements meet the National Commission for Quality Assurance (NCQA), federal, and State specifications and requirements. Policies submitted by **HCI** clearly outlined operational processes and procedures for evaluating initial and recredentialing applications, verifying required credentialing elements, applicant record approval, decision making to determine denial or disenrollment of network participation, and notification of determination. **HCI**'s policy, *Discipline Specific Credentialing Criteria for Practitioners*, provided a comprehensive account of the minimum credentialing criteria that each applicant must meet based practitioner specialty type, education/training, applicable licensure or certification, professional liability, and other requirements. Review of the cover letter for participating providers that accompanied initial credentialing applications, practitioner disenrollment letters, National Credentialing Committee (NCC) agenda, and NCC meeting minutes further demonstrated **HCI** 's credentialing program processes and workflows.

Prior to the site review, HSAG randomly selected five credentialing, five recredentialing, and four organizational provider administrative records to assess compliance with federal regulations and contract requirements related to credentialing and recredentialing of practitioners, and assessment of organizational providers (e.g., inpatient facilities, residential facilities, and ambulatory/outpatient facilities). Review of the administrative records approved on or between January 1 and December 31, 2020, demonstrated **HCI**'s timely primary source verification of licenses, education/training, work history, history of professional liability, State and Medicaid sanctions/exclusions, and practitioner applications/attestations. As a result of the coronavirus disease 2019 (COVID-19) pandemic, NCQA acknowledged that some activities during 2020 may have experienced challenges related to timeliness. NCQA extended a grace period for the provider and practitioner recredentialing activity cycle by two months, increasing the time frame to 38 months. **HCI** had only one recredentialing organization provider record that had an approval date that occurred within the additional two-month grace period established by NCQA.

Summary of Findings Resulting in Opportunities for Improvement

HCI's policy, *Provider Rights and Notification*, noted that practitioners were notified of their rights via the cover letter that accompanied the credentialing and recredentialing application packet. The detailed procedures outlined that, in addition to the provider rights, practitioners were informed of the time frame for making corrections, the format for submitted corrections, and where corrections could be submitted. However, the cover letter did not include this specific guidance. HSAG recommends that **HCI**'s application packet cover letter reflect the practitioner rights as detailed in the *Provider Rights and Notification* policy.

Summary of Required Actions

HCI's policy, *Prevention and Monitoring of Non-Discriminatory Credentialing and Recredentialing*, described that the Director of National Credentialing or their designee annually reviewed 3 percent of the denied applications to ensure that there were no incidents of discrimination. However, **HCI** and Beacon staff members described that the sample of applications were extracted from the "universe" of credentialing and recredentialing files denied across all regions served by Beacon's NCC. **HCI** staff members further explained that the random selection of 3 percent of denied applications reviewed may or may not result in **HCI** practitioner files being selected and incorporated in the audit. To demonstrate the audit was conducted annually during the review period, **HCI** submitted the *Practitioner Credentialing Quality Control Annual Denials Audit for Potential Discrimination* report; however, the document, dated May 27, 2020, did not indicate any of the 11 providers' affiliated health plans. **HCI**'s policies, processes, and procedures must ensure representation of denied **HCI** practitioner file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination occurs on behalf of the NCC and/or reviewer.

While **HCI**'s policy, *Integrity of Provider Data in Practitioner and Organizational Provider Directories and Other Enrollee Materials*, described processes for completing a quality review of selected practitioner credentialing files, collecting data changes, testing usability of the provider directory system, and evaluating member comprehension and the usefulness of the provider directory systems, the policy did not describe a process or procedure for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty. **HCI** submitted a supporting document with three sentences, one of which referenced "100 detailed written standard operating procedures and workflows" in place to ensure consistent listings of practitioner credentialing information; however, the supporting document did not demonstrate a clear process. **HCI** must implement a written process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

HCI's administrative service agreement with Beacon clearly outlined all delegated activities, services, reporting responsibilities, performance standards, and terms. **HCI** delegated functions including, but not limited to, staffing, office space and furnishings, financial services, member management, network provider management, quality management, medical management, information technology (IT), and reporting of deliverables. **HCI** confirmed that it maintained the ultimate authority over all delegated functions. **HCI** conducted monthly joint operations meetings (JOMs) with Beacon on the last Monday of every month to discuss critical issues and department updates. **HCI** demonstrated this oversight activity through submitted JOM agendas for April and September 2020. **HCI** reported conducting a full audit of all delegated activities and services in 2019. No deficiencies were identified, but **HCI** described using the evaluation of administrative services to implement process improvements across its organization and delegated relationship with Beacon.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HCI's administrative service agreement included language describing that contractors must permit and cooperate with inspections or evaluations conducted or initiated by the Department, the United States Department of Health and Human Services (HHS), and/or CMS; however, the agreement language did not include the other specific language and details required. **HCI** must update contracts and delegated agreements to include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

HCI's quality assessment and performance improvement requirements were supported through detailed policies, procedures, and complex reporting both at the corporate level and information that was disseminated to individual departments and the provider network. All **HCI** quality functions were delegated to Beacon. Delegation monitoring was accomplished through an annual delegation audit and routine reporting to **HCI**'s board of directors.

Key changes noted in calendar year (CY) 2020 included the onboarding of Beacon's IT and quality directors who added increased focus on Lean Six Sigma approaches, such as streamlining data requests, storage, and data production procedures, with the ultimate goal to provide staff members with timely and meaningful information.

Quality topics were addressed in a variety of meeting venues such as with the board of directors; compliance oversight committee; quality improvement/utilization management (QIUM); program improvement advisory committee (PIAC); member experience advisory committee (MEAC); and the member services subcommittee that discussed complaints, grievances, and appeals. **HCI** noted approaches to increase member attendance and comfort levels at the MEAC, including efforts to start local MEAC groups.

HCI's *Quality Improvement Plan* and annual *Quality Report* described a comprehensive quality assurance and performance improvement (QAPI) program that included strategies aimed to improve the health of the region's members. Mechanisms to address member over- and underutilization of services included various reports and associated procedures, such as a report that featured **HCI**'s top 50 users. Underutilization was monitored through specialized care management programs for various diagnoses, and chart audits for BH and SUD services were used to further assess quality of care.

HCI adopted and disseminated clinical practice guidelines (CPGs) based on reliable evidence, including nationally recognized professional organizations and scientific bodies, and with input from the scientific review committee (SRC). These CPGs were reviewed and voted on by the SRC every two years or as necessary, then presented to the corporate medical management committee (CMMC) for final approval. **HCI** established a policy outlining how the CPGs are used in care management decisions and as an indicator of quality of care in the recredentialing process for providers.

HCI used grievance data and population-based analyses to identify member access and needs, and monitored members' perceptions of health status through a variety of surveys as demonstrated in the QAPI program materials. Examples included the *Experience of Care and Health Outcomes* (ECHO®)[1-2] survey, the *Your Opinion Matters* survey, and the *Consumer Assessment of Healthcare Providers and*

[1-2] ECHO® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Systems (CAHPS®)[1-3] survey. The QIUM committee discussed results from the surveys for monitoring and planning and presented the *Your Opinion Matters* survey to the MEAC for feedback. **HCI** used this feedback and data analysis to produce member educational materials, such as brochures that reminded members about family therapy and alternative treatment options. Low scoring providers were addressed through CAPs as necessary. Quality of care (QOCs) concerns were handled by the quality department and sometimes investigated concurrently with the grievance department.

The *Beacon Data Flows* document demonstrated the **HCI** workflow used for collection, analysis, integration, and reporting of data from internal and external sources. **HCI** sent necessary encounter files to the Department in the required 837 format before reporting back to provider groups, finance, and administration through the use of an *Encounters Report Card*.

Summary of Findings Resulting in Opportunities for Improvement

Although **HCI** noted that member disenrollment data could be tracked through noted differences between month-to-month enrollment and disenrollment data, HSAG recommends that **HCI** enhance the ability to track and review this information, particularly when **HCI** becomes aware of any members who have disenrolled for reasons other than loss of Medicaid eligibility through notification from the State or County departments. Despite reflecting a small subset of the overall population, this information may include valuable quality indicators. Tracking disenrollment reasons for those other than loss of Medicaid eligibility will further align **HCI** with the requirements outlined in 42 CFR 438.242(a) and 42 CFR 438.56.

Summary of Required Actions

HSAG did not identify any opportunities for improvement that resulted in required actions.

[1-3] CAHPS® is a registered trademark of AHRQ.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. 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, 2020, through December 31, 2020. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials.

HSAG also reviewed a sample of the RAE's administrative records related to both RAE credentialing and RAE recredentialing 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 five records for each of credentialing and recredentialing. Using a random sampling technique, HSAG selected the samples from all RAE credentialing records, and all RAE recredentialing records that occurred between January 1, 2020, and December 31, 2020. For the record review, the RAE received a score of *Met (M)*, *Not Met (NM),* or *Not Applicable (NA)* for each required element. HSAG separately calculated a record review score for each record review requirement and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in

subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services.

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 four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality 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.

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **HCI** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals. **HCI** was required to:

Related to coverage and authorization of services, **HCI** was required to complete one corrective action:

- Ensure the notice of adverse benefit determination letters are written in a language that is easy for the member to understand.

Related to access and availability, **HCI** was required to complete one corrective action:

- Develop a robust mechanism to monitor timely access to services.

Related to grievances and appeals, **HCI** was required to complete six corrective actions:

- Develop a mechanism to ensure the description of the grievance resolution in the member letter thoroughly addresses the member's complaint.
- Clarify details about the State fair hearing (SFH) in the appeal resolution letter as well as in the information distributed to providers (five required actions).

Summary of Corrective Action/Document Review

HCI submitted a proposed CAP in June 2020. HSAG and the Department reviewed and approved portions of the CAP. **HCI** submitted initial documents as evidence of completion in October and November 2020. **HCI**'s final submission was reviewed and accepted as completed in January 2020.

Summary of Continued Required Actions

HCI successfully completed the FY 2019–2020 CAP, resulting in no continued corrective actions.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract Amendment #4: Exhibit B-4—9.1.6	**Documents Submitted:** 1. R4_NetworkAdequacyPln_FY20-21-Page 2 and 4-5 2. PRCO 010 Network Development Process- Entire Document 3. R4_GeoAccess Compliance- Entire Document **Description of Process:** Beacon Health Options has policies in place to select providers (PRCO 010 Network Development Process) and develops an annual Network Adequacy Plan (R4_NetworkAdequacyPln_FY20-21) that outlines the strategies for selection and retention of providers. The plan is based on the monitoring of the network throughout the year through the review of the GeoAccess Compliance to identify network needs and incorporate into the selection of providers. For retention of providers "HCI develops and maintains good collaborative relationship [with providers]." This includes trainings, ongoing support and issue resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* RAE Contract Amendment #4: Exhibit B-4—9.3.4.2.1; 9.3.5	**Documents Submitted:** 1. N_NCQA_Medicaid_MBHO_Certificate - Entire Document 2. N_CR218.09_CredCriteria_Facility- Entire Document-*Misc. **Description of Process:** Beacon Health Options, as delegated by the RAE for credentialing, manages the credentialing activities through the service center located in Latham, New York which retains "status of full for the development and maintenance of a	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	clinically effective managed behavioral healthcare delivery system, which maintains as its primary objective the delivery of high quality Member care and services" (NCQA_Medicaid_MBHO_Certificate). As part of the credentialing and recredentialing process, Beacon Health Options ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. This process is documented in the policy N_CR218.09_CredCriteria_Facility.	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.1-2	**Documents Submitted:** 1. N_CR 226.08_Prevent_Monitor_Non-Discriminatory_CredReCred-Page 1-2 2. BH_Practitioner_Agreement-Page 8, Section 6.2 **Description of Process:** Beacon Health Options does not discriminate as per BH_Practitioner_Agreement against providers for acting within the scope of their license or providing services to Members that require costly treatment. Additionally, Policy N_CR 226.08_ Prevention and Monitoring of Non-discriminatory Credentialing and Recredentialing states that Beacon does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, or sexual orientation; licensure or certification; the type of procedure or patient in which the practitioner specializes; or specializes in the conditions that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.4	**Documents Submitted:** 1. N_Practitioner Notice of Denial-Entire Document 2. R4_NetworkAdequacyPln_FY20-21-Page 2 and 3 **Description of Process:** Beacon, as the delegated entity for HCI, uses the R4_NetworkAdequacyPln_FY20-21 to ensure that have the appropriate number and type of providers needed for its Members and maintain a fair cost-based reimbursement practice. Beacon Health Options notifies providers, in writing, of any decision to deny inclusion of practitioners in the network and the reason for the denial. Beacon informs them of their ability to reapply in six (6) months for reconsideration.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract Amendment #4: Exhibit B-4—9.1.13	**Documents Submitted:** 1. BH_Practitioner_Agreement_Executed Example – Entire Document 2. R4_PCP_Practitioner_Agreement_Executed Example – Entire Document **Description of Process:** Beacon, as the delegated entity for HCI, completes and maintains a signed contract or participating agreement with each practitioner in the network. This is evidenced by	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	examples of signed behavioral health practitioner agreement and signed primary care provider agreement. See: • BH_Practitioner_Agreement_Executed Example – Entire Document • R4_PCP_Practitioner_Agreement_Executed Example – Entire Document	
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—9.1.15, 17.9.4.2.5, 17.10.5.1-2	**Documents Submitted:** 1. N_CR 211.08 Ongoing Monitoring of Provider Sanctions – Entire Document-*Misc. 2. OIG Checks Example – Entire Document **Description of Process:** Beacon Health Options, as the delegated entity, on a monthly basis "collects and reviews reports related to credentialed practitioners and facility/organizational providers" including OIG. Evidence is the policy N_CR 211.08 Ongoing Monitoring of Provider Sanctions. Beacon logs sanctions review for documentation purposes as noted in the OIG Checks Example.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—17.9.4.2.1-4	**Documents Submitted:** 1. N_CR 206.13 Primary Source Verification-Page 4, 6-7 *Misc. 2. PSV Checks Example – Entire Document **Description of Process:** Beacon Health Options, as the delegated entity, includes within its credentialing elements a process by which to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	monitor "any persons defined as disclosing entities with more than 5% ownership or control". Beacon "queries the National Practitioner Data Bank within 180 calendar days of the final credentialing decision date to verify if there have been any disciplinary actions against clinical privileges, sanctions or adverse actions enacted against provider by licensure boards, exclusions or disbarments by Medicare, or Medicaid, any reported sanctions, fraudulent activity, professional misconduct, or criminal offenses". Any identified sanctions or exclusions for those individuals are presented to the National Credentialing Committee for appropriate action. Evidence is the policy N_CR 206.13 and the sanction checks as seen in the Primary Source Verification PSV Checks Example.	
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	**Documents Submitted:** 1. N_CR 226.08_Prevent_Monitor_Non-Discriminatory_CredReCred-Page 1-2 2. BH Provider Handbook-Page 12 *Misc. 3. BH_Practitioner_Agreement-Page 29 **Description of Process:** Beacon Health Options has policy N_CR226.08_Prevent_Monitor_Non-Discriminiatory_CredReCred where it states that Beacon does not discriminate against providers who act within the scope of his/her license for advising or acting on the behalf of Members. Additionally, the BH_Practitioner_Agreement states that the agreement has nothing that "prohibits, or otherwise restricts, a health care professional from acting within the law of practice, from advising or advocating on behalf of an MCD	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.102(a)(1) RAE Contract Amendment #4: Exhibit B-4—14.7.3	(Medicaid) Member who is his or her patient." Finally, this information is also outlined in the BH_Provider Handbook.	
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* RAE Contract Amendment #4: Exhibit B-4—7.3.6.1.13-14, 14.4.7	**Documents Submitted:** 1. BH Provider Handbook-Page 24 *Misc. 2. R4_PCP Provider Handbook-Page 25 3. 310L_NonDiscrimination - Entire Document **Description of Process:** Beacon Health Options does not discriminate which makes the reporting to the State moot. The full policy, 310L_NonDiscrimination, affirms its position on non-discrimination with a clear statement on I.a. (page 1) that it does not "discriminate against Members because of race, religion, gender, age, disability, health status or sexual orientation, in the context of receiving care and services from Beacon Health Options Colorado and its providers". Additionally, should a behavioral health provider not offer services due on moral or religious grounds, Beacon, as stated on the Behavioral Health Provider Handbook, has a process in place to assist the Member to secure a behavioral health provider, including out of network that will offer the services. As for a Primary Care Provider, stated in the R4_PCP Provider Handbook, in accordance with the Department of Health Care Policy & Financing, providers may not dismiss Members based on the Member's gender, race, religion, or sexual orientation. Due to Beacon's policy to not discriminate, the Member cannot be dismissed due to moral or religious reasons.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although HCI reported that the organization does not have any moral or religious objections to services, neither the BH provider manual nor the PH provider manual included language to confirm this approach.		
Required Actions: HCI must update informational materials to clarify that, while an individual provider may have such objections, HCI as an organization does not. Furthermore, HCI should provide additional information stating that, if the provider objects to services, the member should be referred back to HCI to be assigned to a different provider if needed.		
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines.	**Documents Submitted:** 1. R4_CompPln_FY20-21-Page 4-9 2. R4_CompCommittee_MeetingMinutes_07172020 – Entire Document 3. N_CO101.8_ComplianceProgramActivities – Entire Document **Description of Process:** HCI has a Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) that is reviewed periodically to ensure it includes all required elements. It is the cornerstone of all Compliance activities. On "Element I: Written Policies, Procedures and Standards of Conduct" Page 4-5, it outlines the standards of conduct for HCI and its commitment to comply with all federal, State and contract requirments. The Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) in "Element II: Compliance Officer, Committee, Governing Body, and Senior Management Involvement" Page 5 designates a compliance officer who is responsible for developing and implementing policies and procedures to ensure compliance with requirements of the contract. This position reports directly to the CEO and Board of Directors. HCI has a Compliance Committee whose	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract Amendment #4: Exhibit B-4—17.1.3, 17.1.5.1-7	structure is outlined in the R4_Compliance and Fraud, Waste & Abuse Plan under Corporate Compliance Committee, Governing Body, Senior Management Involvement section in pages 5-6 outlines the Compliance Commitee structure and responsibility. The plan and structures are reviewed during Compliance Committee meetings, as evidenced in the meeting minutes R4_CompCommittee_MeetingMinutes_07172020. The Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) in "Element III: Effective Training and Education" Pages 6-7 describes training requirements across all levels of the organization. Compliance Program and Compliance Structure (see R4_Compliance Program page 5, and R4_Compliance Structure, page 6), outlines the compliance training structure. The Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) in "Element IV: Effective Lines of Communication" Page 7 describes the process by which the Compliance Officer communicates formally with the Board of Directors and all staff with the organization. The Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) in "Element V: Effective Systems for Routine Monitoring, Auditing and Identification of Compliance Risks" pages 7-8 describes the routine monitoring and auditing of compliance risks. Beacon, as the delegated entity, has policies in place to execute the monitoring and auditing of compliance risks, see N_CO101.8_ComplianceProgramActivities.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) in "Element VI: Enforcing Standards Through Well Publicized Disciplinary Standards" page 8 outlines the requirements for expectations for proper conduct. "Element VII: Procedures and Systems for Prompt Response to Compliance Issues" pages 8-9 describes the prompt response to "reports of potential non-compliance or suspected FWA or privacy incidents".	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6-8)* RAE Contract Amendment 4: Exhibit B-4—17.1.6, 17.1.5.9, 17.7.1, 17.5.1	**Documents Submitted:** 1. R4_CompPln_FY20-21– Pages 9-19 2. R4_CompCommittee_MeetingMinutes_07172020 – Entire Document 3. R4_MonthlyFWARpt – Entire Document 4. R4_FWARpt_SemiAnnual – Entire Document **Description of Process:** HCI has a Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) that is reviewed periodically to ensure it includes all required elements, as evidenced in the meeting minutes R4_CompCommittee_MeetingMinutes_07172020. In the R4_CompPln_FY20-21, the FWA Plan Purpose and Scope section (pages 9-19) states the purpose of HCI's FWA Plan is to demonstrate the manner in which HCI and affiliated entities comply with the requirements of the Deficit Reduction Act of 2005 and its obligations related to FWA. Any contractor who received or made Medicare/Medicaid payments in the amount of at least five (5) million dollars	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	during the previous Federal Fiscal Year must comply with all federal requirements for employee education regarding Federal False Claims Act, any applicable state False Claims Act, the right of employees to be protected under Qui Tam (whistleblower) provisions and the organization's policies and procedures for detecting and preventing FWA (Pages 12-13 of of R4_CompPln_FY20-21). To the extent known and within three (3) business days of learning of the matter, employees report the allegation, the identity of the provider or other individuals at issue, and the time period in question via the MCO Suspected Fraud Written Notice template to the Department and the Medicaid Fraud Control Unit (MFCU). HCI will suspend payments to a provider after HCI, its clients, and/or government agencies determine there is a credible allegation of fraud for which an investigation is pending against the provider, as defined in 42 C.F.R. §455.23 (Page 13 of R4_CompPln_FY20-21). HCI reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding Fraud, Waste, and Abuse, including overpayments, please find copies of the monthly reports if file titled R4_MonthlyFWARpt and R4_ FWARpt_SemiAnnual.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.7.2-5, 17.1.5.7.1, 17.1.5.7.6, 17.3.1.3.2.1, 17.3.1.1.2.3-4, 17.3.1.3.1.1	**Documents Submitted:** 1. R4_CompPln_FY 20-21– Pages 9-19 2. R4_CompCommittee_MeetingMinutes_07172020 – Entire Document 3. R4_MCOSuspectedProviderFraud_WrittenNotice – Entire Document 4. R4_Notification_Member_Changes – Entire Document 5. R4_Notification_Provider_Changes – Entire Document 6. Sampleletter_HCI-Entire Document **Description of Process:** HCI has a Compliance and Fraud, Waste & Abuse Plan (see R4_CompPln_FY20-21) that is reviewed periodically to ensure it includes all required elements, as evidenced in the meeting minutes R4_CompCommittee_MeetingMinutes_07172020. In the R4_CompPln_FY20-21, FWA Plan Overview – Mandatory Reporting states Employees, providers, and contractors are required to report any identification or suspicion of FWA. To the extent known and within three (3) business days of learning of the matter, employees are to report the allegation, the identity of the provider or other individuals at issue, and the time period in question via the MCO Suspected Fraud Written Notice template to the Department and the Medicaid Fraud Control Unit (MFCU). Please find same as evidence in "R4_MCOSuspectedProviderFraud_WrittenNotice". To the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	extent practical, HCI maintains and respects the confidentiality and privacy of all employees, providers and vendors in the course of the investigation and resolution of any reported incident. Employees must cooperate fully with any investigation. Failure to comply with the provisions of this paragraph may result in disciplinary action, up to, and including, termination. FWA Plan Procedures, D. Resolution 1. Reporting Requirements (See R4_CompPln_FY20-21 page 15) and FWA Plan Procedures, Section B. Detection, #3 Member Service Verification Surveys see Sampleletter_HCI. On an annual basis, Beacon sends out Member verification surveys to a sample of selected RAE Members to solicit response confirming that services have been received by Members as billed. HCI has a process in place to notify the State when there are changes in Member's circumstances that affect their eligibility. An example of the notification is R4_Notification_Member_Changes. HCI has a process in place to notify the State when there are changes in provider's circumstances that affect their participation in the network. An example of the notification is R4_Notification_Provider_Changes.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608(b)* RAE Contract Amendment #4: Exhibit B-4—9.2.1.1, 9.3.2, 17.9.2	**Documents Submitted:** 1. N_CR 206.13 Primary Source Verification-Page 5 *Misc. 2. Providers_Pend_Disenrollment_Example – Entire Document **Description of Process:** Beacon Health Options, as the delegated entity, conducts primary source verification during initial credentialing and recredentialing. This includes review of Medicaid enrollment through the States processes as outlined in the policy N_CR 206.13 Primary Source Verification. On a weekly basis, Beacon runs a report of providers pending disenrollment and includes reason for the disenrollment. The report is reviewed by Network staff to confirm disenrollment is accurate. Once confirmed, Member Services is notified to send letter to affected Members. Enclosed is an example of the report and internal communication regarding the termination "Providers_Pend_Disenrollment_Example."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract.	**Documents Submitted:** 1. N_CO 434 Conflict of Interest – Entire Document 2. N_ CO 29 Screening Against Exclusion – Entire Document 3. R4_QuarterlyFinInfo_Q1FY20-21 on tab: Admn PMPM Exp. 4. PCP_Practitioner_Agreement-Page 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.608(c) RAE Contract Amendment #4: Exhibit B-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	**Description of Process:** Beacon, as the delegated entity for HCI, has policy N_CO 434 Conflict of Interest to require individuals to disclose and update Beacon on potential conflict of interest issues and outlines the process for handling any disclosures. Additionally, Beacon has policy N_CO 29 Screening Against Exclusion in place "not to employ, contract, conduct business with individuals or entities listed by a federal agency or state law enforcement, regulatory or licensince agency as excluded, suspended, debarred, or otherwise ineligible to participate in federally funded health care programs...or who have been identified as potential terrorists or having connections with terrorists" and establishes a process and guidelines for performing exclusion screening checks as required by federal and state agencies on all applicable individuals. For Primary Care Providers, regarding the capitation payments or other payments in excess of the amounts specified in the contract, HCI conducts monthly payments to the Primary Care Providers for the Per Member Per Month, which are reviewed and approved by Beacon staff as well as RAE management. The amounts paid are based on the Member attribution issued by the Department of Health Care Policy & Financing for the payment month. Should there be an over or underpayment or other error, the payment is automatically adjusted on the subsequent payment to the provider. Additionally, since the month-to-month payments vary, PCP_Practitioner_Agreement states that provider is able to request review of payments when they determine may be	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	incorrect by a margin of ten percent (10%) or more within thirty (30) days of the receipt of the payment. This information is reported to HCPF on the quarterly finance report, see R4_QuarterlyFinInfo_Q1FY20-21 on tab Admn PMPM Exp.	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.8, 17.3.1.2.4.4	**Documents Submitted:** 1. BH_Practitioner_Agreement-Page 11 2. BH_Provider Handbook-Page 45 *Misc. 3. PCP_Practitioner_Agreement-Page 9 4. R4_MonthlyFWARpt- Entire Document 5. R4_FWARpt_SemiAnnual – Entire Document 6. R4_QuarterlyFinInfo_Q1FY20-21 on tab Admn PMPM Exp. 7. BH_Provider Support Call Presentation - Page 16-19 8. BH_Claims Submission Reminder – Entire Document **Description of Process:** For Behavioral Health network, BH_Practitioner_Agreement requires providers to cooperate in the efforts to recover overpayments. Under the BH_Provider Handbook, it states that providers are responsible for "routinely review claims and payments in an effort to assure that they...have not received overpayments. When overpayment is identified, the Provider must notify Beacon of the received or identified overpayment, return the payment and include the reason for the overpayment in writing within sixty (60) calendar days after the date on which the overpayment was identified." Behavioral Health Providers are informed about this	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	requirement in June 2020 through a Provider Alert "BH_Claims Submission Reminder" and during a provider support call on January 8, 2021, see BH_Provider Support Call Presentation. For Primary Care Providers, regarding the capitation payments or other payments in excess of the amounts specified in the contract, HCI conducts monthly payments to the Primary Care Providers for the Per Member Per Month, which are reviewed and approved by Beacon staff as well as RAE management. The amounts paid are based on the Member attribution issued by the Department of Health Care Policy & Financing for the payment month. Should there be an over or underpayment or other error, the payment is automatically adjusted on the subsequent payment to the provider. Since the month-to-month payments vary, PCP_Practitioner_Agreement states that provider is able to request review of payments when they determine may be incorrect by a margin of ten percent (10%) or more within thirty (30) days of the receipt of the payment. This information is reported to HCPF on the quarterly finance report, see R4_QuarterlyFinInfo_Q1FY20-21 on tab Admn PMPM Exp. HCI reports to the Department of Health Care Policy & Financing on a monthly and semi-annual basis any activities regarding Fraud, Waste, and Abuse, including overpayments, please find copies of the monthly reports if file titled R4_MonthlyFWARpt and R4_ FWARpt_SemiAnnual.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract Amendment #4: Exhibit B-4—14.14.1-2, 17.14.2-4	**Documents Submitted:** 1. BH_Practitioner_Agreement -Page 11 2. BH_Provider_Handbook- Page 40 *Misc. 3. BH_Provider Support Call Presentation- Page 20 **Description of Process:** Behavioral Health Providers are required to "not balance bill Members for covered services rendered". This is included in the BH_Practitioner_Agreement as well as the BH_Provider_Handbook. Behavioral Health Providers were informed about this requirement during a provider support call on January 8, 2021, see BH_Provider Support Call Presentation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity							
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 VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RAE Contract Amendment #4: Exhibit B-4- 9.3.4.2.1	Note: These are NCQA MBHO requirements available at the time of drafting this tool (6/2020). **Documents Submitted/Location Within Documents:** 1. CR 224.04 Development and Approval of Policies and Credentialing Criteria -Page 1, Section I **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. The above policy details and outlines the development of credentialing policies to align with NCQA standards and federal, state, and clinic regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*	**Documents Submitted/Location Within Documents:** 1. CR 225.10 Discipline Specific Credentialing Criteria for Practitioners-Page 1-16, Section IV.B.1-21 **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. Beacon requires potential and current practitioners/providers to submit specific information to meet the minimal credentialing criteria requirements for inclusion in the Beacon provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(a) NCQA CR1—Element A1	network. The above policy outlines those specific disciplines and the criteria of these disciplines that must be met for Beacon network inclusion.	
2.B. The verification sources it uses. NCQA CR1—Element A2	**Documents Submitted/Location Within Documents:** 1. N_CR 206.13 Primary Source Verification; Pages 3-6, Section IV.A-D-*Misc. 2. CR 206A Primary Source Verification – Additions and Exception Sources; Pages 1-2, Section II **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. The above policy outlines the approved primary sources Beacon Credentialing utilizes to verify discipline-specific criteria during the credentialing process to meet NCQA requirements. Addendum policy CR 206A outlines state-specific mandated verifications to support the met requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted/Location Within Documents:** 1. CR 225.10 Discipline Specific Credentialing Criteria for Practitioners-Page 1-16, Section IV.B.1-21 **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. Beacon requires potential and current practitioners/providers to submit specific information to meet the minimal credentialing criteria requirements for inclusion in the Beacon provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted/Location Within Documents:** 1. CR 203.09 Practitioner Credentialing Process-Pages 4-5, Section IV.G.2; 2. CR 209.09 Practitioner Recredentialing Process-Page 4-5, Section IV.F.4 **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. The policies above outline and detail the credentialing and recredentialing processes through to the method of decision-making.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted:** 1. CR 210.06 Roles, Responsibilities and Reimbursement of the National Credentialing Committee-Page 1, Section II ; Page 2, Section IV.E.1-2 **Description of Process:** The above policy details the role of the National Credentialing Committee and its Medical Director in the approvals of credentialing files that meet the required criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	**Documents Submitted:** 1. CR 226.08 Prevention and Monitoring of Non-Discriminatory Credentialing and Recredentialing-Page 2, Section IV.A-E **Description of Process:** The above policy details the process to ensure non-discrimination during the credentialing and recredentialing processes which is reviewed by management and any such potential findings are escalated for review by the National Credentialing Committee.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: HCI's policy, *Prevention and Monitoring of Non-Discriminatory Credentialing and Recredentialing*, described that the Director of National Credentialing or their designee annually reviews 3 percent of the denied applications to ensure that there were no incidents of discrimination; however, HCI and Beacon staff members described that the sample of applications were extracted from the "universe" of credentialing and recredentialing files denied across all regions served by Beacon's NCC. HCI staff members further explained that the random selection of 3 percent of denied applications reviewed may or may not result in HCI practitioner files being selected and incorporated in the audit. To demonstrate the audit was conducted annually during the review period, HCI submitted the *Practitioner Credentialing Quality Control Annual Denials Audit for Potential Discrimination* report; however, the document, dated May 27, 2020, did not indicate any of the 11 providers' affiliated health plans.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: HCI's policy, processes, and procedures must ensure representation of denied HCI practitioner file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination on behalf of the NCC and/or reviewer.		
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Documents Submitted:** 1. CR 205.08 Provider Rights and Notification-Page 2, Section IV.A.2, C **Description of Process:** The above policy details the reasons and methods for notifying a practitioner of found conflicting information submitted by a practitioner during the credentialing process and attempts to verify the information submitted.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**Documents Submitted:** 1. CR 203.09 Practitioner Credentialing Process-Page 3, Section IV.G ; 2. CR 209.09 Practitioner Recredentialing Process-Page 4, Section IV.F.4 **Description of Process:** The above policies each mandate that following the credentialing and recredentialing processes leading to approval, practitioners are to be notified of their credentialing status within sixty (60) calendar days, contingent upon state-mandated regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Documents Submitted:** 1. CR 210.06 Roles, Responsibilities and Reimbursement of the National Credentialing Committee-Page 2, Section IV.A, E.1 **Description of Process:** The above policy details the role of the National Credentialing Committee's Medical Director as The Chair when overseeing the credentialing approvals and/or escalated practitioner and provider file reviews.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Documents Submitted:** 1. CR 207.06 Confidentiality of Provider Specific and Other Credentialing Information-Pages 2-4, Section IV.A-E, H **Description of Process:** The above policy outlines and details the system control requirements for the credentialing processes of recording, safeguarding and securing information, and managing stored information within the utilized electronic credentialing system.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Documents Submitted:** 1. CR 208.06 Integrity of Provider Data in Practitioner and Organizational Provider Directories and Other Enrollee Materials-Page 1, Section I; Page 2, Section IV.F **Description of Process:** The above policy details the requirement for data collected during the credentialing process to align	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with the information for each practitioner when uploaded to the provider directory.	
Findings: While HCI's policy, *Integrity of Provider Data in Practitioner and Organizational Provider Directories and Other Enrollee Materials*, described processes for completing a quality review of selected practitioner credentialing files, collecting data changes, testing usability of the provider directory system, and evaluating member comprehension and the usefulness of the provider directory systems, the policy did not describe a process or procedure for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty. HCI submitted a supporting document with three sentences, one of which referenced "100 detailed written standard operating procedures and workflows" in place to ensure consistent listings of practitioner credentialing information; however, the supporting document did not demonstrate a clear process.		
Required Actions: HCI must implement a written process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty.		
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	**Documents Submitted:** 1. CR 205.08 Provider Rights and Notification- Page 2, Section IV.A.1 **Description of Process:** The above policy details the reasons and methods of notifying a practitioner of the right to review information submitted as supporting and supplemental materials for credentialing during the application review process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	**Documents Submitted:** 1. CR 205.08 Provider Rights and Notification- Page 2, Section IV.A.2; Page 3, Section IV.C.1 **Description of Process:** The above policy details the practitioners' right to correct erroneous information found during the credentialing process by notification and response methods made available.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents Submitted:** 1. CR 205.08 Provider Rights and Notification-Page 2, Section IV.A.3 **Description of Process:** The above policy details the right of practitioners to receive notification regarding the status of his or her credentialing application and the methods to outreach for this information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	**Documents Submitted:** 1. CR 210.06 Roles, Responsibilities and Reimbursement of the National Credentialing Committee-Page 1, Section I **Description of Process:** The above policy mandates the National Credentialing Committee to employ a peer review process to arrive to the decision-making processes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	**Documents Submitted:** 1. CR 210.06 Roles, Responsibilities and Reimbursement of the National Credentialing Committee-Page 2, Section IV.A, Section IV.E.2 and Section IV.E.1 **Description of Process:** The above policy outlines the Membership and disciplinary types of the National Credentialing Committee and the Members' collective responsibilities regarding the review of credentialing practitioners and providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days.) • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply*	**Documents Submitted:** 1. N_CR 206.13 Primary Source Verification; Pages 3-6, Section IV.A-D.1*Misc. **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. The policy above outlines and details the approved primary verification sources and methods of use according to these NCQA standards and state-mandated requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member. NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents Submitted:** 1. N_CR 206.13 Primary Source Verification; Page 5, Section IV.B.9-13*Misc. **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. The policies above outline and detail the approved primary verification sources and methods of use according to these NCQA standards and state-mandated requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions.	**Documents Submitted:** 1. CR 203.09 Practitioner Credentialing Process-Page 3, Section IV.F 2. CR 209.09 Practitioner ReCredentialing Process-Page 3, Section IV.D **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	activity in accordance with NCQA Credentialing Standards and Guidelines. The above policies outline the required disclosure questions practitioners applying to Beacon Health Options' network must respond to and attest to during the credentialing application review process.	
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Documents Submitted:** 1. CR 209.09 Practitioner Recredentialing Process-Page 1, Section I **Description of Process:** Beacon Health Options, Inc. is delegated responsibility for credentialing and recredentialing activity in accordance with NCQA Credentialing Standards and Guidelines. The above policy details the requirement of practitioners and providers to return or make available a current, completed application, to ensure compliance, the recredentialing process continues for completion within thirty-six (36) months from the previous date of credentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events.	**Documents Submitted:** 1. N_CR 211.08 Ongoing Monitoring of Provider Sanctions-Page 2-5, Section IV*Misc. **Description of Process:** The above policy outlines and details the reports and resources utilized to perform the ongoing monitoring	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	of Medicare, Medicaid, state-mandated sanctions and licensure limitations of its enrolled practitioners and providers. The policy supports the actions taken when adverse actions are identified.	
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**Documents Submitted:** 1. CR 213.08 Practitioner, Provider Appeal Rights, Range of Actions, and Appeal Process-Pages 3-4, Section IV.C.1-2 and Pages 2, Section IV.B.2 **Description of Process:** The above policy details how Beacon notifies a practitioner or organizational provider of the appeal process, reason(s) for the notification, and the rights of each to pursue appeal. This policy also details the range of actions available to a participating practitioner or provider determined to have adverse action taken against him or her or the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable*	**Documents Submitted:** 1. N_CR 218.09_CredCriteria_Facility-Page 2, Section IV.A.1*Misc. **Description of Process:** The above policy details the criteria that must be met during the credentialing process of an organizational/facility provider including verification methods of licensure.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable. NCQA CR7—Element A1		
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Documents Submitted:** 1. N_CR 218.09_CredCriteria_Facility-Page 2, Section IV.A.5*Misc. **Description of Process:** The above policy details the verification, as applicable, of an organizational provider/facility's accreditation through approved accrediting body.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards.*	**Documents Submitted:** 1. N_CR 218.09_CredCriteria_Facility-Page 2, Section IV.A.5; IV.E.4*Misc. **Description of Process:** The above policy details that in the event an organizational provider/facility is not accredited or licensed by a state licensing agency, a site visit will be conducted, where applicable and is contingent upon provider type.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(Exception: Rural areas.) NCQA CR7—Element A3		
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Element B	**Documents Submitted:** 1. N_CR 218.09_CredCriteria_Facility-Page 2, Section III*Misc. **Description of Process:** The above policy outlines the organization provider/facility types that meet the criteria for Beacon credentialing as providing mental health and/or substance abuse services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses behavioral health care providers every 36 months. NCQA MBHO CR7—Element C	**Documents Submitted:** 1. CR 219.07 Facility and Organizational Provider Recredentialing Process-Page 1, Section I; Page 2, Section IV.F **Description of Process:** The above policy details organization providers/facilities must be recredentialed within thirty-six (36) months, or otherwise as required by the state-mandated regulation of the provider/facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. If the Contractor delegates credentialing/re-credentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	**Documents Submitted:** 1. CR 220.09 Delegation of Credentialing and Recredentialing-Page 2, Section I.F.1-5, Page 4, Section IV.B.2, Page 8, Section IV.D.1, and Page 6, Section IV.C.6-7 **Description of Process:** The above policy details the processes of delegation of credentialing and recredentialing in the evaluation for meeting criteria, review of audit materials, the methods of handling the results of the auditing, and the rights to making final determinations following delegation auditing, both as a results of pre-delegation and continued delegation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Documents Submitted:** 1. CR 220.09 Delegation of Credentialing and Recredentialing-Page 4, Section IV.B.2 **Description of Process:** The above policy details the requirement for among pre-delegation review, the delegate must submit documentation including policies and procedures to be followed during the credentialing process of the delegate.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	**Documents Submitted:** 1. CR 220.09 Delegation of Credentialing and Recredentialing-Page 6, Section IV.C.2, Page 6, Section IV.C.4 and Page 4, Section IV.B.2 **Description of Process:** The above policy details the processes of delegation of credentialing and recredentialing in the annual evaluation for meeting criteria, review of audit materials against standards, the methods of handling the results of the auditing, and the at-least semi-annual evaluation of requested reports.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Documents Submitted:** 1. CR 220.09 Delegation of Credentialing and Recredentialing-Page 8, IV.C.16 **Description of Process:** The above policy details the delegate's opportunity to improve its methods and performance post-audit should the annual audit result in deficiencies resulting in a corrective action plan(s). Monitoring will result to determine if deficiencies have been corrected, which upon review will lead to the determination of whether or not delegation may continue.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	29
				Total Score ÷ Total Applicable		=	94%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.1	**Documents Submitted:** 1. Administrative Services Agreement-Page 2 Section 2.1-*Misc **Description of Services:** Per the HCI Administrative Services Agreement with Beacon Health Options, HCI maintains ultimate authority over all delegated functions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements.* *42 CFR 438.230(b)(2) and (c)(1)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	**Documents Submitted:** 1. Administrative Services Agreement-Page 1 Section 1.1, Page 5 Section 6.2 – 6.3, Pages 10-21 Description of Services-*Misc **Description of Services:** Per the HCI Administrative Services Agreement with Beacon Health Options, Beacon is delegated all non-clinical services required for performance of the Medicaid contract. The Administrative Services Agreement goes on to further outline the specific scope of services and deliverables agreed upon. The Agreement also provides for corrective actions or revocations for performance concerns.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6	**Documents Submitted:** 1. Administrative Services Agreement-Page 1 Purpose of Agreement, Page 1 Section 1.1, Page 2 Section 1.2-1.3, Page 3 Section 4.1, Page 6 Section 7.0, Page 8 Section 8.16-8.17, Page 22-*Misc **Description of Services:** Per the HCI Administrative Services Agreement with Beacon Health Options, Beacon as the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.	**Documents Submitted:** 1. Administrative Services Agreement-Page 2 Section 1.3, Page 4 Section 5.1-5.3-*Misc **Description of Services:** Per the HCI Administrative Services Agreement with Beacon Health Options, the State CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any and all applicable records.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6		
Findings: HCI's administrative service agreement included language describing that contractors must permit and cooperate with inspections or evaluations conducted or initiated by the Department, HHS, and/or CMS; however, the agreement language did not include the other specific language and details required.		
Required Actions: HCI must update contracts and delegated agreements to include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.		

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

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* RAE Contract Amendment #4: Exhibit B-4—16.1.1	**Documents Submitted:** 1. Administrative Services Agreement-Page 15 Quality Management section *Misc 2. R4_QualityImprovePln_FY20-21- Entire Document 3. R4_QualityRpt_FY20-21- Entire Document 4. FY21_HCI_QM Work Plan_Final- Entire Document 5. QIC_UM_MeetingMinutes_2020SOCT07-Page 2, number 4 6. R4PopMangPln_FY20-21_FINAL-Entire Document **Description of Process:** HCI delegates all quality management functions to Beacon Health Options (Administrative Services Agreement). Beacon Health Options, along with the HCI Quality Improvement /Utilization Management Committee (QIUM) develops an annual Quality Report, Annual Quality Plan and Work Plan see (R4_QualityImprovePln_FY20-21, R4_QualityRpt_FY20-21, FY21_HCI_QM Work Plan_Final) which details the planned quality improvement activities for the fiscal year. The QIUM committee reviews the progress on the work plan (FY21_HCI_QM Work Plan_Final) quarterly to discuss progress made towards performance improvement. R4PopMangPln_FY20-21_FINAL details HCIs strategic plan to improve the health of the regions Members. This plan is used to create a framework to guide HCIs activities in order to accomplish the goals of ACC Phase II.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *For RAEs two PIPs are required, one for physical health and one for behavioral health.* *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—16.3.1, 16.3.5, 16.3.8	**Documents Submitted:** 1. MCO_PIP-Val_Module 1_Submission Form_WellChecksR4-Final-Entire Document 2. MCO_PIP-Val_Module 2_Submission Form_WellChecksR4 –Final-Entire Document 3. MCO_PIP-Val_Module 3_Submission Form_R4_CastilloPC_V5-Entire Document 4. PIP-Val_Module 4_Submission Form_Final_Revised-Entire Document 5. RAE4_CO2019-20_PH_Well Check_PIP-Close-Out_Submission Form_D1-Entire Document 6. MCO_PIP-Val_Module 1_Submission Form_PC_to_BHR4_Final_V4-Entire Document 7. MCO_PIP-Val_Module 2_Submission Form_PC_to_BHR4_Final-V4-Entire Document 8. MCO_PIP-Val_Module 3_Submission Form_Final-Entire Document 9. MCO_PIP-Val_Module 4_Submission Form_V4_R4_BH-Entire Document 10. RAE4_CO2019-20_BH_Depression_PIP-Close-Out Submission Form_D1_v4_reviewed -Entire Document 11. CO2019-20_MCD_TechRpt_D1-Pages 3-53 through 3-57 12. PDSA Worksheet_02-03-20-Entire Document 13. PDSA Worksheet_F1_R4_HCI-Entire Document **Description of Process:** In collaboration with the Department, HCI selected two (2) performance improvement projects (PIP) topics in FY19. HCI selected as their topics: • Increasing Well Checks for adult Members ages 21-64	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Increasing mental healthcare services after a positive depression screening The topics were to be completed through the rapid cycle process that concluded in June of 2020. The intent of the PIPs was to have one (1) PIP that addressed physical health and one (1) PIP that addressed behavioral health. HCI progressed through the first four (4) modules of the rapid cycle program earning validation for each module. See documents: • MCO_PIP-Val_Module 1_Submission Form_WellChecksR4-Final • MCO_PIP-Val_Module 2_Submission Form_WellChecksR4 –Final • MCO_PIP-Val_Module 3_Submission Form_R4_CastilloPC_V5 • PIP-Val_Module 4_Submission Form_Final_Revised • MCO_PIP-Val_Module 1_Submission Form_PC_to_BHR4_Final_V4 • MCO_PIP-Val_Module 2_Submission Form_PC_to_BHR4_Final-V4 • MCO_PIP-Val_Module 3_Submission Form_Final • MCO_PIP-Val_Module 4_Submission Module 5 was stopped by HCPF and HSAG due to the competing priorities posed by the COVID-19 Pandemic. The progress of the PIPs and their associated interventions is detailed in the closeout documents: HCI received validation for modules 1-4 both PIPs from HSAG as seen in:	

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	• RAE4_CO2019-20_PH_Well Check_PIP-Close-Out_Submission Form_D1 • RAE4_CO2019-20_BH_Depression_PIP-Close-Out Submission Form_D1_v4_reviewed For the Well Check PIP, HCI used claims data to address the efficacy of the interventions implemented. This data was used in order to track and trend the number of well check visits completed by male Medicaid Members after receiving the approved intervention. This data was then interpreted to determine if the intervention was effective or not. See the document titled: RAE4_CO2019-20_PH_Well Check_PIP-Close-Out_Submission Form_D1 for an assessment of the data used and the effectiveness of the interventions employed. For the Behavioral Health PIP, HCI was able to partner with an organization and use real time data calculated by the organization in order to test the effectiveness of the proposed interventions. See the document titled: RAE4_CO2019-20_BH_Depression_PIP-Close-Out Submission Form_D1_v4_reviewed for an assessment of the data used and the effectiveness of the interventions employed. Furthermore, in order to assess performance improvement and the applicability for the associated interventions, HCI completed a PDSA study for each PIP. The aim of the PDSA study was to address the increasing or sustainable improvement associated to each intervention for the two PIPs. The PDSA studies can be seen in the following documents: • PDSA Worksheet_02-03-20-Entire Document • PDSA Worksheet_F1_R4_HCI-Entire Document	

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	In addition, PIP activities and progress as noted by the Department are articulated in: • CO2019-20_MCD_TechRpt_D1-Pages 3-53 through 3-57 This document demonstrates the validation and progress made on the Well Check and Behavioral Health PIPs. Finally, beginning in September of 2020, HCI began work on the new rapid cycle PIP topics. HCI has begun work on the PIP topic of: Depression Screening and Follow–up After a Positive Depression Screen.	
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* RAE Contract Amendment #4: Exhibit B-4—16.4.1, 16.4.4	**Documents Submitted:** 1. R4_CareCompactQ2_FY20-21-Entire Document 2. HealthNeighborhood_Moveit-Entire Document **Description of Process:** The current process for the calculation of the performance measurement data for the Behavioral Health Incentive Measures (BHIM) and the Key Performance Indicators (KPIs) rests with the State of Colorado. The State currently calculates the performance for the RAEs on these measures. HCI does submit quarterly performance on part one of the Health Neighborhood measure. See R4_CareCompactQ2_FY20-21. This data is loaded to the State Moveit site quarterly. See (HealthNeighborhood_Moveit).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract Amendment #4: Exhibit B-4—16.6.1	**Documents Submitted:** 1. R4 Performance Slides_10-23-20-Entire Document 2. RAE Region 4 UM Report 10.26.2020-Entire Document 3. QIUM_MeetngMinutes_2020NOV-Page 3 Section 5, Page 4 Section d. 4. AuditReport_FY20_HCI-Entire Document 5. ClinicalAuditTool-Entire Document 6. SLVRMC_Care Coordination Audit Tool_Final-Entire Document 7. R4_QualityImprovePln_FY20-21- Page 4-17 8. Coup Pilot Q1FY21-Entire Document 9. ChrtAudResults_CHCI_2020-Entire Document 10. R4_FY21 Project Plan Milestone Table_10.09.20-Entire Document 11. Top 50 Report - Health Solutions_2020-12-03-09-30-01-Entire Document 12. RAE4 FY21Q1 Penetration Rates by Eligibility-Entire Document 13. Copy of IP Readmissions_HCI-Entire Document 14. MCO_PIP-Val_Module 1_Submission Form_PC_to_BHR4_Final_V4-Entire Document 15. MCO_PIP-Val_Module 2_Submission Form_PC_to_BHR4_Final-V4-Entire Document 16. MCO_PIP-Val_Module 3_Submission Form_Final-Entire Document 17. MCO_PIP-Val_Module 4_Submission Form_V4_R4_BH-Entire Document 18. R4_FY21_PAC_Project_Plan_10-09-2020-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: HCI ensures mechanisms are in place to detect and evaluate both over- and under-utilization, as noted in the Annual Quality Improvement Plan (R4_QualityImprovePln_FY20-21). Regular audits take place to assess service utilization. Results of these audits are demonstrated in: • AuditReport_FY20_HCI • ClinicalAuditTool and • ChrtAudResults_CHCI HCI audits network providers to ensure that services are appropriately utilized. Furthermore, accountable entities in RAE region 4 are also audited for compliance with care coordination requirements. These audits can provide insight into the manner in which Members are being connected with and utilizing services. See SLVRMC_Care Coordination Audit Tool_Final. In addition, COUP Pilot Q1FY21 demonstrates that HCI is actively engaged in what is called a COUP lock-in Diversion program. The aim of the COUP pilot program is for COUP Members to address overutilization of services. The COUP pilot program addresses over utilization of services that would make a Member appropriate for lock-in services through the RAE. The care coordination entities in Region 4 responsible for the highest volume of COUP Members were identified and agreed to implement the new COUP pilot program: the entities were Health Solutions and Valley-Wide Health Systems. If the COUP pilot program is found to be appropriate to extend to other care coordination entities that will be addressed at that time.	

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	Mechanisms in place to monitor both over- and under-utilization include: RAE Region 4 UM Report 10.26.2020 communicate the Membership utilization trends and are reviewed monthly at the HCI QIUM meeting. In addition, as seen in R4 Performance Slides_10-23-20, performance in the Key Performance Indicators (KPIs) and Behavioral Health Incentive Measures (BHIM) are also reviewed monthly for performance trends. See QIUM_MeetngMinutes_2020NOV. HCI has selected three of the region's five (5) highest potentially avoidable cost/complication (PAC) episodes for intervention. The PAC Plan aims to reduce costs for the three (3) highest cost episodes of care. These episodes of care are: • Substance Use Disorder • Diabetes • Maternity R4_FY21 Project Plan Milestone Table_10.09.20 and R4_FY21_PAC_Project_Plan_10-09-2020 detail the efforts that are being targeted for these episodes of care. It is believed that these interventions will directly affect the costs ties to the over and underutilization of these services. Over-utilization of behavioral health services: Using authorization or claims data, we can determine an average or typical utilization pattern for our Members. This can be defined by an aggregate metric, such as total cost of care, or for a specific level of care of type of service. For example, we might be interested in learning how many outpatient psychotherapy visits are used per year by an average Member who accesses that level of care. We can then use that benchmark to identify	

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	individuals who are statistical outliers and who may represent over-utilization. These cases can then be reviewed to determine whether the higher than average utilization is clinically appropriate. Two (2) examples of over-utilization indicators are our Top 50 Report - Health Solutions_2020-12-03-09-30- (quarterly) and Copy of IP Readmissions_HCI reports (daily). The Top 50 Report - Health Solutions_2020-12-03-09-30-is a measure of the total cost of care for a Member. It combines paid claims and the value of encountered services provided by the CMHC. This report identifies the highest cost utilizers during a specified time period. These reports are distributed to our CMHC partners and they review the utilizations patterns to identify any anomalies. If an anomaly is identified, the Clinical or Quality team can request additional documentation of medical necessity and the rationale for the higher than expected utilization. The daily Copy of IP Readmissions_HCI report identifies clients who are currently in an inpatient facility who have had one (1) or more additional hospitalizations within the prior sixty (60) days. Individuals who appear on this list can be targeted for enhanced discharge planning/follow-up. We also track thirty (30) day readmission rates on an aggregated basis for each of our contracted inpatient facilities. This practice allows us to identify specific facilities that may be performing below average on this measure. Under-utilization of behavioral health services: The measurement of under-utilization is somewhat more complicated than measuring over-utilization; it is essentially monitoring what should have happened, but did not. For example, we can use AE4 FY21Q1 Penetration Rates by	

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	Eligibility as a measure of under-utilization with the expectation that various racial groups or eligibility (aid category) groups have similar clinical utilization. If the overall penetration rate for the population is fifteen (15%) percent, we would perhaps hypothesize that each sub-group should have a similar penetration rate. If the data does not support this expectation, we would then question why a specific group had lower than expected utilization. Asking such questions helps the RAE identify any potential barriers to access or engagement. We also can use Copy of IP Readmissions_HCI reports to identify clients that may be under-utilizers of post-discharge clinical services. The underlying assumption is that clients who fail to engage in outpatient services after hospitalization are more likely to re-admit to a hospital. Therefore, we can identify and review clients with more frequent than average readmissions to determine whether there has been a failure to engage. Furthermore, the behavioral health performance improvement project which focuses on the utilization of psychotherapy services after a positive depression screen is another includes mechanisms to detect under-utilization of services. • MCO_PIP-Val_Module 1_Submission Form_PC_to_BHR4_Final_V4-Entire Document • MCO_PIP-Val_Module 2_Submission Form_PC_to_BHR4_Final-V4-Entire Document • MCO_PIP-Val_Module 3_Submission Form_Final-Entire Document • MCO_PIP-Val_Module 4_Submission Form_V4_R4_BH-Entire Document	

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5. The Contractor's QAPI program includes mechanisms for identifying, investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. RAE Contract Amendment #4: Exhibit B-4—16.7.1.1, 16.7.2	**Documents Submitted:** 1. QOC_AcknowledgementLtr_HCI-Entire Document 2. QOC_ResolutionLtr_HCI -Entire Document 3. R4_QOCC_Minutes_2020September8_QM-Entire Document 4. QM 4.34_national-Entire Policy 5. QM 4H Adverse Incidents, QOC Issues and Outlier Practice Patterns-Entire Document 6. ADVINCSUMMARY_FY20_HCI-Entire Document 7. CAPRequest_Template_Revised2020_QM-Entire Document 8. R4_QOCStateReport_Template-Entire Document **Description of Process:** HCI has a policy which establishes a process for investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. The process is detailed in the quality of care policies. See (QM 4.34_national and QM 4H Adverse Incidents, QOC Issues and Outlier Practice). Investigations are completed on reported serious reportable events that are classified as major or sentinel events; if a potential quality of care issue is identified during the investigation of an adverse incident, it is documented as a quality of care issue as well. If it is found that a corrective action is warranted, a corrective action plan is requested. See: CAPRequest_Template_Revised2020_QM. Any reported quality of care concerns are investigated and reviewed by the Quality of Care Committee (QOCC) for investigational review and disposition at the monthly QOCC meeting or as needed. The document titled	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	R4_QOCC_Minutes_2020September8_QM provides a summary example of how HCI reviews and investigates QOC issues and the subsequent investigation to date that was included for Committee review in the corresponding QOCC. An example of a quality of care tracking can be seen in R4_QOCStateReport. As indicated in the Quality of Care (QOC) policy (QM 4H Adverse Incidents, QOC Issues and Outlier Practice Patterns), an acknowledgement letter is sent (QOC_AcknowledgementLtr_HCI), and an investigation completed when a QOC is reported. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the Member. Once the QOC is closed, a resolution letter will be sent to parties involved. See QOC_ResolutionLtr_HCI. Since adverse incidents may also be quality of care issues, all serious reportable events are evaluated upon receipt to determine whether there are any urgent safety issues to be addressed. See (QM 4H Adverse Incidents, QOC Issues and Outlier Practice Patterns and ADVINCSUMMARY_FY20_HCI). The QOCC reviews the results of the investigation and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action.	
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a*	**Documents Submitted:** 1. QOC_AcknowledgementLtr_HCI-Entire Document 2. QOC_ResolutionLtr_HCI -Entire Document 3. QM 4H Adverse Incidents, QOC Issues and Outlier Practice Patterns-Entire Document 4. ADVINCSUMMARY_FY20_HCI-Entire Document 5. AuditReport_FY20_HCI-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school. *42 CFR 438.330(b)(4)* RAE Contract Amendment #4: Exhibit B-4—16.2.1.4 10 C.C.R. 2505-10, 8.205.9	6. ClinicalAuditTool-Entire Document 7. R4_QOCC_Minutes_2020September8_QM-Entire Document 8. QIUM_MeetngMinutes_2020NOV-Secion F i-v 9. SLVRMC_Care Coordination Audit Tool_Final-Entire Document 10. R4_QualityImprovePln_FY20-21- Pages 4-16, 19 and 46-47 11. R4_QualityRpt_FY20-21-Page 25 12. Documentation Training-Slide 12 13. ChrtAudResults_CHCI_2020-Section E5 14. Policy_248L_EPSDT-Entire policy 15. Creative Solutions MW Meeting Notes-Entire Document 16. HCI Care Coordination R4-262L Policy-07.01.2020-Entire Document 17. HCI Complex Care Coordination Plan_FINAL-UPDATED 07.01.2020-Entire Document **Description of Process:** HCI, uses several instruments to assess the quality and appropriateness of care provided to all Members. Behavioral health providers are audited through a variety of activities and are expected to complete assessments to identify and recommend treatment for individuals with special health care needs. Documents referenced below address the oversight that HCI maintains over its provider network in order to ensure that the care being delivered is appropriate.	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	See: AuditReport_FY20_HCI, ClinicalAuditToolDocument, and ChrtAudResults_CHCI demonstrate the audits that network providers are subject to. R4_QualityImprovePln_FY20-21 and R4_QualityRpt_FY20-21 demonstrate the various audits that HCI conducts, along with a synopsis of each. On a quarterly basis, providers are invited to attend a Mental Health and SUD documentation training session. See (Documentation Training). At these sessions, providers learn about documentation standards and the audit requirements. Providers are trained on and audited for EPSDT compliance during regularly conducted chart audits. See ChrtAudResults_CHCI_2020. In addition, per Policy_248L_EPSDT, it is the policy of COS_EC to coordinate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) with other practitioners and agencies for clients aged twenty (20) and under. Members with special needs are supported through case management where care is well coordinated and constant communication between providers is occurring. See SLVRMC_Care Coordination Audit Tool_Final. As indicated in the Quality of Care (QOC) policy (QM 4H Adverse Incidents, QOC Issues and Outlier Practice Patterns), an acknowledgement letter is sent (QOC_AcknowledgementLtr_HCI), and an investigation completed when a QOC is reported. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the Member. Once the QOC is closed, a resolution letter will sent to parties involved. See QOC_ResolutionLtr_HCI. Since adverse incidents may also be quality of care issues, all serious reportable events are evaluated upon receipt to determine whether there are any	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	urgent safety issues to be addressed. See (QM 4H Adverse Incidents, QOC Issues and Outlier Practice Patterns and ADVINCSUMMARY_FY20_HCI). The QOCC reviews the results of the investigation (R4_QOCC_Minutes_2020September8_QM) and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. See QIUM_MeetngMinutes_2020NOV for a review of the ADVINCSUMMARY_FY20_HCI. Creative Solutions MW Meeting Notes demonstrates that HCI is involved in meetings to address difficult situations for Members who are developmentally disabled (DD). The creative solutions meetings focus on bringing together interdisciplinary teams (IDT) to address the needs of Members with DD and need special services. Creative solutions meetings are usually initiated by HCPF when an EPSDT request has been made. These meetings bring together multiple stakeholders and payers, including the RAEs, DHS, school systems, and individual providers. They attempt to define roles and responsibilities for these various systems of care. In many cases, the Member has complex medical or educational needs in addition to any identified behavioral health needs. Beacon typically assigns an Intensive Case Manager (ICM) to these cases, sometimes in addition to the Member's primary Care Coordinator, and they remain attached to the case until the Member has stabilized or the issues have been resolved. Any provider or Member representative can convene a creative solutions meeting to ensure that systems of care are working collaboratively.	

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	HCI Care Coordination R4-262L Policy-07.01.2020 and HCI Complex Care Coordination Plan_FINAL-UPDATED 07.01.2020 both demonstrate roles and responsibilities of HCI Accountable Care Coordinators with regard to special populations (i.e., complex Members and care coordination activities within the Accountable Care Collaborative 2.0 Program).	
7. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • CAHPS survey • ECHO survey RAE Contract Amendment #4: Exhibit B-4—16.5.1-2, 16.5.6	**Documents Submitted:** 1. CO2020_ECHO Survey_Member_ExperienceRpt_Final_July2020-Entire Document 2. ECHO Survey interventions_FINAL-2020Mar26-Entire Document 3. Beacon-BRO-MM-FamilyTherapy_v1PRINT-Entire Document 4. R4_CAHPS Results Summary-Entire Document 5. HCI_CAHPS_ECHO_PP_V2-Entire Document 6. QIC_UM_MeetingMinutes_2020JAN08_Final-Page 1 A-F. 7. QIC_UM_MeetingMinutes_Draft_2020FEB05-Page 3, d. 8. QIC_UM_MeetingMinutes_Approved_2020APR01-Page 2, f. 9. FY21_HCI_QM Work Plan_Final-FY21 HCI QMWP Slide, Rows 27-30 10. Data_All_HCI_201218- Entire Document 11. facebook post_family in treatment-Entire Document 12. HCI_MEAC Summary_09JUN2020-Entire Document 13. HCI_Trending Report_FY19-20-Entire Document 14. Phone Data_FY19-20-Entire Document **Description of Process:** HCI monitors Members' perceptions of well-being and functional status as well as accessibility and adequacy of services through review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	of various Member surveys. Three (3) surveys used are the ECHO survey, the Your Opinion Matters Survey and the Consumer Assessment of Healthcare Providers and Systems **(**CAHPS) survey. These reports are reviewed for trends within the RAE as well as comparisons across other RAEs. **ECHO Satisfaction Survey** HCI found that two (2) areas of low reporting satisfaction on the ECHO survey correlated to the questions addressing the availability of other treatment options and the rate at which family Members were involved in treatment. See HCI_CAHPS_ECHO_PP_V2, and CO2020_ECHO Survey_Member_ExperienceRpt_Final_July2020. HCI continues efforts to affect the positive responses received from Members on these two (2) elements even though there will not be an ECHO survey in FY21. HCI has set a performance goal at seventy (70%) percent for these two (2) categories. In order to make Members aware of the availability of alternative treatment options and the importance of involving the family in treatment, HCI took on the following activities: See ECHO Survey interventions_FINAL-2020Mar26 and Beacon-BRO-MM-FamilyTherapy_v1PRINT. • Met with region providers to discuss the initiatives and discuss the interventions that would be meaningful. • Created email communications to network providers addressing the importance of the involvement of family in therapy and where their Members could find information on alternative treatment options. • Posted information for the Member on the HCI Facebook page (facebook post_family in treatment) to let Members know	

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	about alternative treatment options and to ask their therapist about involving their family in their therapy. • Presented information about family therapy and alternative treatment options at Provider Relation led practice support calls. • Created a brochure that was sent out to practices for Members to read that promoted the importance of their family participating in their treatment. • Presented this information at QIUM asking those in attendance to pass along the ECHO interventions to their clinicians. In addition, results and trends detected in the survey responses, will be reviewed at QIUM and discussions will be held for possible interventions. See QIUM Minutes (QIC_UM_MeetingMinutes_Approved_2020APR01 and QIC_UM_MeetingMinutes_Draft_2020FEB05). **Your Opinion Matters Survey** The Your Opinion Matters survey aims to collect information on Member interest to improve their healthcare, and perceptions of satisfaction and access issues for both physical health and behavioral healthcare services. HCI reviews the Results of the Your Opinion Matters Survey twice per year. The next review is scheduled for January 2021. See FY21_HCI_QM Work Plan_Final-FY21 HCI QMWP for the associated work plan goal for the ECHO survey. The Survey (see Data_All_HCI_201218) has also been discussed with the RAE at QIUM. HCI continues to conduct outreach to Members who indicate on the survey that they would like a follow-up contact. In FY20, sixteen (16) Members have taken the survey and four (4) Members have indicated	

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	that they would like to receive more information about their Health First Colorado Benefits or to speak to someone regarding their questions or concerns. In addition, if there are downward trends detected in the survey responses, these trends will be reviewed at QIUM and discussions will be held for possible interventions. When Members were asked, "What would make your healthcare better?" three (3) Members indicated through the survey that they were happy with the services that they received through HCI. The next highest response category was "Talking with my provider more" three (3) and "Help with understanding my dental benefit" three (3). In addition to the survey being reviewed at QIUM, this survey was taken to the Member Experience Advisory Council (MEAC) meeting where the survey was reviewed with Members. Additionally, two (2) new options for service selection were added to reflect telehealth services obtained for physical health and behavioral health. The responses to the survey, (where and when applicable) will be used to address any comments and concerns relayed by the Member. The Member Experience Advisory Council (MEAC) felt the following questions should be added: • Did you receive a referral at your appointment? • Did the referral happen timely? • Do you feel your personal health information was protected and kept confidential? • Did you feel you were respected and listened to during your visit? • Did your provider use your preferred pronouns?	

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Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Consumer Assessment of Healthcare Providers and Systems In FY2019-20, HCI has taken the results from the FY2018-19 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program to better understand patient experience with health care and develop to: • Assess patient experience. • Report survey results. • Help organizations use the results to improve the quality of care. The CAHPS data and low-scoring elements notated in the survey were addressed at the QIUM committee (See R4_CAHPS Results Summary-Entire Document, HCI_CAHPS_ECHO_PP_V2 and QIC_UM_MeetingMinutes_2020JAN08_Final). It was determined that low scoring elements for Valley-Wide Health Systems would be examined for patient experience improvement. HCI and Valley-Wide met to address areas where their performance was below the mean for providers in their region. It is important to note that while Valley-Wide's scores were below the mean; their scores were still high and were considered high performance. Valley-Wide determined that they would like to focus on areas in the survey that were related to access to care for children. Valley-Wide will focus on the following questions: • Question 13. In the last six (6) months, when you contacted this provider's office to get an appointment for care your child needed right away, how often did you get an appointment as soon as your child needed? • Question 15. In the last six (6) months, when you made an appointment for a check-up or routine care for your child with	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	this provider, how often did you get an appointment as soon as your child needed? • Question 18. In the last six (6) months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day? In efforts to continue improved patient experience with healthcare, HCI has taken the data from the 2019-2020 CAHPS survey and continues to work with Valley-Wide on the questions addressed above. The data for questions 13, 15, and 18 reflect that the scores were lower than the CO RAE 2020 Average for Valley-Wide. Valley-Wide's scores did go down for question 18. The responses to question 15 went up. Question 13 results remained steady with previous year's results. HCI will continue to work with Valley-Wide to address areas of low performance. HCI monitors and reviews Beacon's call center data on a quarterly basis. The average call answering rate between July 1, 2019 and June 30, 2020 was ninety-seven (97.4%) percent. The average answering speed for each call was eighteen (18) seconds. The call abandonment rate was two and a half (2.6%) percent during the fiscal year. See Phone Data_FY19-20. HCI reviews the grievance and appeal quarterly report at the quarterly Quality Management meeting. There were one hundred and thirty-eight (138) complaints filed by one hundred and five (105) Members during July 1, 2019 through June 30, 2020. There were seventeen (17) complaints regarding access and availability which accounts for twelve percent (12%) of complaints. HCI reviews if Members are in	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agreement with the complaint resolution. Of the one hundred and five (105) Members who made complaints, ninety-five (95) of the Members were in agreement with the resolutions which results in ninety percent (90%) of Members agreeing with the resolution of their complaint. HCI reviewed requests for twenty-six (26) appeals. Eighteen (18) of those appeals were not processed because HCI did not receive the request within sixty (60) days and/or a Designated Client Representative (DCR) form was not included. HCI processed eight (8) appeals in a timely manner during July 1, 2019 and June 30, 2020. See HCI Trending Report_FY19-20. HCI meets quarterly with Members at their regional Member Experience Advisory Council (MEAC). The primary objective of this meeting is to listen to Members' experience in health care. Members discussed Health Colorado's Member survey – Your Opinion Matters in the June 9, 2020 meeting. The survey was reviewed to evaluate the efficacy of the questions which measure access to services. See HCI_MEAC Summary_09JUN2020. HCI summarizes the MEAC meetings and posts on their website. See https://www.healthcoloradorae.com/Members/join-a-team/Member-advisory-council/. HCI also provides information to the state's non-emergent transportation company, Intelliride on their website. The purpose of providing this information is to provide resources for Members to increase the probability that they have access to their appointments. See https://www.healthcoloradorae.com/Members/new-Member-welcome-packet/.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract Amendment #4: Exhibit B-4—16.2.5	**Documents Submitted:** 1. FY21_HCI_QM Work Plan_Final-Entire Document 2. R4_QualityRpt_FY20-21-Entire Document 3. R4_QualityImprovePln_FY20-21-Entire Document 4. QIC_UM_MeetingMinutes_2020SOCT07-Page 2, number 4 5. R4_QualityRpt_FY19-20_QualityImprovePln_FY20-21_HCPF Response_Accepted- Entire Document **Description of Process** In order to evaluate the impact and the effectiveness of the Quality Improvement Program, annually HCI completes a work plan (FY21_HCI_QM Work Plan_Final), the annual Quality Improvement Plan (R4_QualityImprovePln_FY20-21) and the annual Quality Report (R4_QualityRpt_FY20-21). Each document addresses the Quality Improvement Program and associated activities and performance on those activities. The work plan is reviewed quarterly at the Region 4 Quality Improvement and Utilization Management Committee (QIUM). See QIC_UM_MeetingMinutes_2020SOCT07 for the review of the work plan. R4_QualityRpt_FY19-20_QualityImprovePln_FY20-21_HCPF Response_Accepted demonstrates that HCPF reviewed and approved the annual quality documents and had no changes required for completion.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members.	**Note:** RAE contract—practice guidelines apply to BH services only. **Documents Submitted:** 1. CSNT 102.5—Entire document 2. RAE Website--Clinical Practice Guidelines--Entire document.docx	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract Amendment #4: Exhibit B-4—14.8.8.1-3	**Description of Process:** This contract element is delegated to Beacon Health Options by the RAE. Policy CSNT 102.5 states that Beacon Health Options develops, revises, and/or adopts Clinical Practice Guidelines (CPGs; also known as treatment guidelines) from nationally recognized sources and scientific bodies, including professional organization (e.g., American Psychiatric Association) based on: • Scientific evidence, • Best practice professional standards, and • Expert input from board-certified physicians from appropriate specialties. Beacon reviews and/or updates CPGs every two (2) years or as necessary. Beacon's Scientific Review Committee (SRC) reviews and/or updates each guideline at least every two (2) years, or more often, if national sources publish updates or make changes to the guideline. In addition, relevant new guidelines can be reviewed, adopted, and approved at any time through the committee process. Updates/changes are then presented to the Corporate Medical Management Committee (CMMC) for final approval. New guidelines can be proposed or developed based on the needs of individual contracts or their Members. The clinical practice guidelines for the RAE are available on the RAE's website. See the website excerpt, RAE Website--Clinical Practice Guidelines.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract Amendment #4: Exhibit B-4—14.8.8	**Documents Submitted:** 1. CSNT 102.5—Entire document 2. RAE Website--Clinical Practice Guidelines--Entire document 3. R4_PCP Provider Handbook page 64; Clinical Practice Guidelines) *Misc 4. https://www.healthcoloradorae.com/providers/provider-resources/ 5. Clinical Practice Guidelines_HCI_RAEWebsite_ScreenShot-Entire Document **Description of Process:** This audit element is delegated to Beacon Health Options by the RAE. Policy CSNT 102.5—Entire document provides detail about how clinical practice guidelines are disseminated to the RAE's affected providers, Members, potential Members, and the public. Section IV.B, in particular, notes that once the guidelines are approved by the Corporate Medical Management Committee (CMMC), the guidelines are posted to Beacon's external website, which is linked to the RAE's website. Beacon's clinical and quality leaders cascade updates about Clinical Practice Guidelines and Resources to applicable team Members and are available to all staff. When necessary, clinical staff may receive additional training through clinical rounds or supervision. Practice guidelines are available to providers through the RAE's website. See website excerpt, RAE Website--Clinical Practice Guidelines--Entire document.docx. Guidelines also are noted in the Provider Handbook. See CO-Behavioral-Health-Medicaid-Provider-Handbook.pdf (p. 64; Clinical Practice Guidelines).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The RAE's Members, potential Members, and the public have access to the clinical practice guidelines through the website's Provider Resources page: https://www.healthcoloradorae.com/providers/provider-resources/ and Clinical Practice Guidelines_HCI_RAEWebsite_ScreenShot. HCI's Member Engagement Specialist is able to direct Members to the website to obtain a couple of the clinical practice guidelines upon request. Members will be mailed a copy of the guidelines upon request free of charge.	
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract Amendment #4: None	**Documents Submitted:** 1. CSNT 102.5--Entire Document 2. Outpatient-Review-Form--page 2 3. ClinicalAuditTool_revised2020June1—Item C6 **Description of Process**: This contract element is delegated from the RAE to Beacon Health Options. In Policy CNST 102.5, it is noted that clinical practice guidelines are communicated to internal clinical staff. The guidelines are utilized in the process of care management, especially in the management of complex cases and/or cases that do not demonstrate expected progress or improvement. These guidelines are often the source of recommendations made during peer-to-peer consultations or provider education to help practitioners make decisions about appropriate treatment planning and intervention in specific clinical circumstances. Care management staff are provided training regarding use of the clinical guidelines during their initial orientation, when new	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	guidelines are developed, or when the guidelines are substantially revised. The application of clinical guidelines and level of care criteria is a routine part of case presentations during clinical rounds. Care management staff are tested annually with an inter-rater reliability examination to assess their consistency in applying clinical criteria and relevant practice guidelines in UM determinations. As part of the re-authorization or concurrent review process, providers are asked to attest that they are providing treatment that is consistent with Beacon's clinical practice guidelines and other professional standards of care. See Outpatient-Review-Form--page 2.pdf. Additionally, provider adherence to guidelines is measure in the audits of clinical records. See item C6 in ClinicalAuditTool_revised2020June1.xlsx.	
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract Amendment #4: Exhibit B-4—15.1.1	**Documents Submitted:** 1. Beacon_Data_Flows - Entire document 2. Encounters_Report_Card_HCI_202010_Final - Entire document 3. Data Tables - Entire document 4. Encounter_Data_Submission_Monitoring_SOP - Entire document **Description of Process:** The Beacon_Data_Flows shows the workflow and servers used to collect, integrate, analyze and report data from internal and external sources. Claims and provider data is sent to the CAS system, which is a secure server based in Ashburn, Virginia. Applicable parts of this data needed for reporting are mirrored locally in the secure server room in the Colorado Springs, CO Beacon Corporate building.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Encounter files are sent to the Colorado Springs location and then uploaded to the CAS system. The workflow document illustrates external data interfaces with Beacon. Data is sent via Secure File Transfer Protocol (SFTP) using a gateway process called FileConnect. Encounters_Report_Card_HCI_202010_Final is the example of reporting of this data. Encounter data is first sent to Beacon by the provider groups. This is stored in Colorado, integrated and then moved to the State, where it is used as a basis to update the calculation of future capitated payments. The resulting encounter files are then reported back to the provider groups, finance and administration as Encounters Report Card (included as reference). The Data Tables document shows the integration and relationship between the table name and the business area. During the design phase of these the RAE database at the beginning of the contract, a decision was made to make the names easy to understand by naming them functionally. This also makes reporting on data more clear and repeatable. A good example of consistency for function are all claim based tables begin with CLM. The data tables listed are to represent the strategy and storage methods of the data. Finally, the SOP HCI Encounter Data Submission Monitoring illustrates in detail, a process that is done monthly to ensure all encounter files are processed. This monitoring is necessary so the State of Colorado can get an accurate picture of how Members are being served. In conclusion, the above mentioned processes, strategies and storage all work toward ensuring the contractor maintains a health information system that collects, analyzes, integrates, and reports data.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B—15.1.1, 8.1	Note: For RAEs, these elements apply only to BH services. **Documents Submitted:** 1. Data_Tables - Entire document 2. Providers_Pending_Disenrollment RAE- Entire document **Description of Process:** If data is required to research issues related to these issues, IT and Reporting teams use the information in the Data_Tables document. The table names are functional; as a result reporting is clearer and repeatable. For example, claim based tables begin with CLM. Certification of providers is stored both in Colorado Spring and in the corporate databases at Ashburn, VA. The IT department ensures that the data for these providers is accessible and up to date from the sources of the data (Provider group, State agency, Corporate IT). Colorado IT mirrors all Colorado provider data from the sources and creates interfaces to allow for the updating of data as it changes. The included artifact, Providers_Pending_Disenrollment RAE, shows an example of the updated as dis-enrolled providers**.** This report is from data stored locally. Member disenrollment activity originates from the State data. We maintain activity of Members even after they are dis-enrolled, according to State guidelines, so data is ready should the Member reenroll.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the	Note: For RAEs, claims/encounter systems relate only to BH capitated services. **Documents Submitted:** 1. Data_Process_Flows_837 - Entire document 2. Functional_Design_Document_Enc_837 Build Process-Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.2	3. Monthly 837 Process Checklist- Entire document **Description of Process:** Data_Process_Flows_837 shows the workflow of getting the eight hundred and thirty-seven (837) files into the Fully integrated platform (CAS). This server as the main storage for all data and reporting. Data is sent via Secure web ftp. The next document is the Functional_Design_Document_Enc_837 Build Process. The project scope of the document (Page 4) describes the full process, "This project covers the monthly 837 build process for CMHC submitted encounter data. CMHCs submit encounter data in a prescribed flat file format. The data is evaluated for more than one hundred possible errors. Accepted records are stored in local SQL Server tables. The 837 data will be extracted from these tables. Perl software programs will extract and format the data into the X12-defined 837 format." The document then describes in detail the step-by-step process. The Monthly 837 Process Checklist ensures that each of the many steps are completed so that the 837 file is correctly submitted.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.1, 15.2.2.3.2	**Documents Submitted:** 1. Encounter_Data_Flow-Entire document 2. Encounter_Sample_Data- Entire document 3. Encounter_Schema- Entire document **Description of Process:** Encounter_Data_Flow is a swimlane document, divided into the CMHC, RAE and HCPF areas. This document illustrates how data moves between these groups and the decision points involved. This document includes both the submission and resubmission process. Encounter_Sample_Data details the header and detail column names and shows an example of what that data looks like. These encounter files are received from the RAE's monthly. The Encounter Schema shows the layout of the column headers that are sent to the State.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts.	**Documents Submitted:** 1. Encounter_Data_Submission_Monitoring_SOP- Entire document 2. FlatFileLayout_Input_from_Providers- Entire document 3. Encounter_Data_Submission_Timeliness_SOP- Entire document 4. File_Connect_Secure_Login_Screen- Entire document 5. Flat_File_Specifications_Output_HCPF- Entire document 6. Example_WC_WC202010RA4BV3.ENC_err- Entire document 7. Example_WC_WC202010RA4BV3.ENC_log- Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.1, 15.2.2.3.5.1	8. Example_WC_WC202010RA4BV3.ENC_mod- Entire document 9. Example_WC_WC202010RA4BV3.ENC_warnings_log- Entire document **Description of Process:** The Encounter_Data_Submission_Monitoring_SOP illustrates in detail a process that is done monthly to ensure all encounter files are processed. This monitoring is necessary so the State of Colorado can get an accurate picture of Member care. Encounters are combined and converted to a flat file format. The FlatFileLayout_Input_from_Providers file shows the header, detail, data dictionary and layout check for this file. This file is sent to HCPF and used as a basis for capitation payments. Encounter_Data_Submission_Timeliness_SOP contains extensive process that is used, including screenshots, to track the encounter files to ensure we have all of the files from each CMHC every month. Collecting the data is done through a web interface called the Electronic Transport System (ETS). The File_Connect_Secure_Login_Screen shows the login screen for this system. Once logged in users can transmit documents securely to the IT department. The encounter files are turned into a flat file which is used by the State. The Flat_File_Specifications_Output_HCPF details the contents of this file.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Lastly, the file products of the testing process are shown in the examples (starting with "Example" listed below). The files are returned to the CMHC's during testing to ensure items such as membership are corrected before the monthly final submission. The State receives the Encounter Flat file monthly. • Example_WC_WC202010RA4BV3.ENC_err • Example_WC_WC202010RA4BV3.ENC_log • Example_WC_WC202010RA4BV3.ENC_mod • Example_WC_WC202010RA4BV3.ENC_warnings_log	
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract Amendment #4: Exhibit B—4-15.2.2.3.2-3, 15.2.2.3.5	**Documents Submitted:** 1. Data_Process_Flows_837- Entire document 2. Functional_Design_Document_ENC_837_Build_Process- Entire document 3. Monthly 837 Process Checklist- Entire document 4. Beacon_Export_837_export_Example **Description of Process:** Data Process Flows 837 shows the workflow of getting the eight hundred and thirty-seven (837) files into the Fully integrated platform (CAS). This server as the main storage for all data and reporting. Data is sent via Secure web ftp. The next document is the Functional Design Document Enc 837 Build Process. The project scope of the document (Page 4) describes the full process, "This project covers the monthly 837 build process for CMHC submitted encounter data. CMHCs submit encounter data in a prescribed flat file format. The data is evaluated for more than one hundred possible errors. Accepted records are stored in local SQL	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Server tables. The 837 data will be extracted from these tables. Perl software programs will extract and format the data into the X12-defined 837 format." The document then describes in detail the step-by-step process. The Monthly 837 Process Checklist ensures that each of the many steps are completed so that the 837 file is correctly submitted. The Beacon_Export_837_export_Example shows what the start of the 837 file that is sent looks like.	

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Health Colorado, Inc. (Region 4)

Review Period:	January 1 through December 31, 2020
Date of Review:	April 6, 2021
Reviewer:	Erika Bowman, BA, CPC
Health Plan Participant:	Elizabeth Yonge

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: ***** Credentialing Date: 12/04/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: ***** Credentialing Date: 03/03/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: ***** Credentialing Date: 09/29/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: ***** Credentialing Date: 05/26/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Health Colorado, Inc. (Region 4)

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #5 Provider ID: ***** Credentialing Date: 01/25/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**5**	**0**	**5**	**0**	**5**	**5**	**5**	**5**	**5**	**5**
Number of Compliant Elements	**5**	**NA**	**5**	**NA**	**5**	**5**	**5**	**5**	**5**	**5**
Percentage Compliant	**100%**	**NA**	**100%**	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**40**
Total Number of Compliant Elements	**40**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

8. Verified that provider is not excluded from participation in federal programs

9. Application must be complete (see compliance tool for elements of complete application)

10. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Health Colorado, Inc. (Region 4)

Review Period:	January 1 through December 31, 2020
Date of Review:	April 6, 2021
Reviewer:	Erika Bowman, BA, CPC
Health Plan Participant:	Elizabeth Yonge

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: ***** Current Recredentialing Date: 02/11/20 Prior Credentialing or Recredentialing Date: 03/14/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: ***** Current Recredentialing Date: 11/10/20 Prior Credentialing or Recredentialing Date: 11/14/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: ***** Current Recredentialing Date: 05/15/20 Prior Credentialing or Recredentialing Date: 06/13/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #4 Provider ID: ***** Current Recredentialing Date: 10/30/20 Prior Credentialing or Recredentialing Date: 11/14/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #5 Provider ID: ***** Current Recredentialing Date: 03/03/20 Prior Credentialing or Recredentialing Date: 04/19/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**5**	**0**	**0**	**5**	**5**	**5**	**5**	**5**	**5**
Number of Compliant Elements	**5**	**NA**	**NA**	**5**	**5**	**5**	**5**	**5**	**5**
Percentage Compliant	**100%**	**NA**	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**35**
Total Number of Compliant Elements	**35**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)

3. Applicable if the practitioner states on the application that he or she is board certified

4. Malpractice settlements in most recent five years

5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **HCI**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager III
Erika Bowman	Project Manager I
HCI Participants	**Title**
Alma Mejorado	Director of Contracting
Alyssa Rose	Chief Operations Officer (COO), Beacon
Barbara Rhodes	Network Education Representative, CO Provider Relations
Cathy Michopoulos	COO, HCI
Courtney Hernandez	Behavioral Health Clinic Quality Audit Analyst, Senior
David McSweeney	Director of Information Technology
Dawn Claycomb	Community Health Worker, Senior
Dr. John Mahalik	Director of Quality Improvement
Dr. Steve Coen	Director of Utilization Management
Elizabeth Yonge	Credentialing Specialist
Guy Reese	Manager I Investigations, Beacon Compliance
Jamie Coahran	Contract Coordinator
Jeremy White	Quality Manager
Joseph Iyongo	Project Manager
Karen Lumpkin	Director of Regional Quality Management
Kat Fitzgerald	Behavioral Health Clinic Quality Analyst
Kristi Williams	Compliance Manager
Lynne Bakalyan	Director, Member Services
Michael Clark	Director of Information Technology & Data
Myron Unruh	Vice President—Colorado Market
Randi Addington	Director, Contract Compliance & Program Innovation
Ron Botten	Manager, Information Technology Account Management
Sheree Marzka	Director II of Compliance
Steve Thiboutot	Systems Analyst II

HCI Participants	Title
Tiffany Jenkins	Manager, Behavioral Health Services
Tina McCrory	Chief Strategy Officer
Zach Hornbaker	Database Administrator, Senior
Department Observers	**Title**
Brooke Powers	ACC Program Specialist
Russell Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2020–2021

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 SAFE 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 2020–2021 Corrective Action Plan for HCI

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* RAE Contract Amendment #4: Exhibit B-4—7.3.6.1.13-14, 14.4.7	Although HCI reported that the organization does not have any moral or religious objections to services, neither the BH provider manual nor the PH provider manual included language to confirm this approach.	HCI must update informational materials to clarify that, while an individual provider may have such objections, HCI as an organization does not. Furthermore, HCI should provide additional information stating that, if the provider objects to services, the member should be referred back to HCI to be assigned to a different provider if needed.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	HCI's policy, *Prevention and Monitoring of Non-Discriminatory Credentialing and Recredentialing*, described that the Director of National Credentialing or their designee annually reviews 3 percent of the denied applications to ensure that there were no incidents of discrimination; however, HCI and Beacon staff members described that the sample of applications were extracted from the "universe" of credentialing and recredentialing files denied across all regions served by Beacon's NCC. HCI staff members further explained that the random selection of 3 percent of denied applications reviewed may or may not result in HCI practitioner files being selected and incorporated in the audit. To demonstrate the audit was conducted annually during the review period, HCI submitted the *Practitioner Credentialing Quality Control Annual Denials Audit for Potential Discrimination* report; however, the document, dated May 27, 2020, did not indicate any of the 11 providers' affiliated health plans.	HCI's policy, processes, and procedures must ensure representation of denied HCI practitioner file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination on behalf of the NCC and/or reviewer.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	While HCI's policy, *Integrity of Provider Data in Practitioner and Organizational Provider Directories and Other Enrollee Materials*, described processes for completing a quality review of selected practitioner credentialing files, collecting data changes, testing usability of the provider directory system, and evaluating member comprehension and the usefulness of the provider directory systems, the policy did not describe a process or procedure for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty. HCI submitted a supporting document with three sentences, one of which referenced "100 detailed written standard operating procedures and workflows" in place to ensure consistent listings of practitioner credentialing information; however, the supporting document did not demonstrate a clear process.	HCI must implement a written process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medicaid enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State,	HCI's administrative service agreement included language describing that contractors must permit and cooperate with inspections or evaluations conducted or initiated by the Department, HHS, and/or CMS; however, the agreement language did not include the other specific language and details required.	HCI must update contracts and delegated agreements to include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* RAE Contract Amendment #4: Exhibit B-4—4.2.12.6		
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 the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

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 Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, 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 RAEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided RAEs with proposed site review dates, group technical assistance and training, as needed. • HSAG confirmed a primary RAE contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site 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 site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and site review activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and 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 RAE also submitted a list of all provider credentialing records and all provider recredentialing records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). The RAE submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review.

For this step,	HSAG completed the following activities:
	HSAG notified the RAE five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct RAE Site Review**
	• During the site review, HSAG met with groups of the RAE's key staff members to obtain a complete picture of the RAE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the RAE and the Department for review and comment. • HSAG incorporated the RAE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the RAE and the Department.