COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2021–2022 Site Review Report

for

Health Colorado, Inc.

Region 4

June 2022

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

Table of Contents

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 and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCM entities and PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities and PIHPs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. 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) 2021–2022 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix C describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2021–2022 and the required template for doing so. Appendix D 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: Sep 27, 2021.

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)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%
V. Member Information Requirements	18	14	12	2	0	4	86%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	6	1	0	0	86%
Totals	**41**	**37**	**34**	**3**	**0**	**4**	**92%**

*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.

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

HCI provided care coordination and continuity of care for all members in Region 4 through three levels of support: 1) primary care medical providers (PCMPs), 2) Accountable Care Coordination Entities, and 3) Beacon Health Options (Beacon) for complex case management. **HCI**'s eight delegated Accountable Care Coordination Entities included High Plains Community Health Center, San Luis Valley Health, San Luis Valley Behavioral Health Group, Health Solutions, Valley-Wide Health Systems, Solvista Health, Southeast Wellness Works, and Plan de Salud del Valle. Each Accountable Care Coordination Entity signed the *Primary Care Medical Provider Agreement*, which designated the PCMP as the primary source for behavioral health and physical health care coordination and case management activities. For PCMPs unable to perform extensive care coordination for members with complex health needs, the delegated Accountable Care Coordination Entity would provide care coordination to those applicable members. Additionally, Beacon provided oversight of **HCI**'s care coordination program as the administrative service organization (ASO). As the ASO, Beacon was able to support the delegated care coordination entities and members with complex and intense care needs. **HCI**'s care coordination policies and procedures documented processes for care coordination and continuity of care for all members.

Members were able to enter care coordination in various ways such as through the call center by speaking to a customer service agent; referrals from community agencies and other RAEs; PCMPs informing members of care coordination services available to them; identifying care coordination needs through the complaints/grievance department; the daily admission, discharge, and transfer (ADT) feed; data workflow through Department-identified members with complex and chronic conditions needing care coordination services; and the *Health Needs Survey*. Once it was determined a member needed care coordination services, the member's PCMP and delegated care coordination entity were identified and made aware of the member needing care coordination. Procedures stated that the care coordinator used three bidirectional attempts and two different modalities to contact the member. Upon contact with the member, the care coordinator completed the **HCI** *Intake Assessment* with the member to identify needs, barriers, and resources needed to access services. The member's answers on the intake assessment triggered additional assessments that should be completed such as the *Community Prepared Tool*, which identifies social determinants of health (SDOH) or the *Patient Health Questionnaire (PHQ)-9*. After being contacted, the member was provided contact information for care coordination including the coordinator's name, phone number, email address, and the 24/7 toll-free number to access care coordination services. After completing the assessment, an *Integrated Whole Person Robust Care Plan* was developed for all **HCI** members enrolled in care coordination. Care plans included appropriate interventions, activities, and short- and long-term goals that were appropriate for the level of care, including the member being placed or remaining in the most appropriate, least restrictive setting. Care coordinators were responsible monitoring, updating, and documenting in the care plan in a timely manner. The Accountable Care Coordination Entities reported all care coordination activities they provided to members once a month to **HCI**.

Staff members discussed the process of comparing the Department's attribution list to member claims activity to verify where the members are actively seeking care. If **HCI** determined a member was utilizing a PCMP from a non-attributed provider, **HCI** informed the Department. The network team reviewed provider data quarterly to verify PCMP locations were correctly affiliated with the State and to assess the attribution level at the location level to check there has not been a drastic change in attributed members. If there were concerns, **HCI** shared the information with the Department, who would determine if **HCI** needed to intervene. If the member requested to change their attributed PCMP, care coordinators and customer service agents assisted the member, including helping the member connect with the enrollment broker.

HCI provided an overview of the electronic care coordination tool, Essette, that collected and aggregated the member's care coordination information, such as the member's name, age, race, name of care coordinator, care coordination notes, stratification level, and information that can aid in the creation and monitoring of the member's care plan. All delegated entities had access to Essette to support communication and coordination among members. Although each Accountable Care Coordination Entity had their own electronic health record (EHR), **HCI** performed care coordination plan audits to assess the quality of documentation contained in the care plans and to provide feedback, as needed. **HCI** utilized a comprehensive care coordination audit tool to assess each entity's compliance with care coordination requirements. Each entity then received a letter with the scores from the audit findings summarizing strengths, recommendations, and opportunities for improvement. If the entity scored below 80 percent, the provider was required to engage in a CAP and repeat audits.

HCI followed policies and procedures to coordinate services between settings of care, including services received from another health plan and community and social support providers to avoid disruption of care for members. Care coordinators outreached members to help them through significant transitions and, if needed, Creative Solutions meetings provided intensive case management and helped arrange additional services. Additionally, care coordinators shared relevant treatment information with entities involved in the member's care to prevent duplication of services. **HCI** had numerous policies and procedures that required providers to maintain member confidentiality and ensured procedures followed Health Insurance Portability and Accountability Act of 1996 (HIPAA) when sharing member information and required member consent as appropriate. Providers had the opportunity to attend quarterly trainings regarding documentation standards and health record maintenance standards, and additional guidance was made available in the *Behavioral Health Provider Manual*.

Summary of Findings Resulting in Opportunities for Improvement

HCI's care coordination and continuity of care policies and procedures provided a high-level overview of the comprehensive care coordination services available to Region 4 members. However, HSAG suggests expanding the language in the applicable policies, procedures, and delegate agreements to better illustrates the roles, responsibilities, and monitoring in place for all those involved in **HCI**'s multi-tiered care coordination delegation model.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

HCI delegated the administrative responsibility of member rights to Beacon. **HCI**'s Member Experience Advisory Council (MEAC) and member engagement team worked to uphold the rights of members. Some of the responsibilities of the member engagement specialist were to discuss and resolve any issues relating to member rights, protection, and confidentiality. The *Member Rights and Responsibility* policy described the various channels used to notify members when there are revisions to **HCI**'s policies. Members were informed of their rights through the member handbook, member newsletters, periodic informational forums, and website postings. Providers received information about member rights through policy statements, the provider manual, and provider emails and were required to display posters at office locations. In addition, members exercised their rights by providing feedback and suggestions, and may report complaints through the ethics hotline. Staff members stated that 90 percent of members report complaints through phone calls or in person.

Staff members and providers were required to read and attest to the *Member Rights and Responsibility* policy as evidenced in the *Employee Attestation of Member Rights* document. The *Provider Round Table* PowerPoint was used to educate providers about the rights and responsibilities of members including the laws that pertain to member rights. Detailed across **HCI**'s documents, members, staff members, and providers are informed that members are free to exercise their rights and doing so should not adversely affect the way they are treated. During the interview, staff members stated that call center associates and providers are trained to assist members regarding member rights.

The *Uses and Disclosure of Protected Health Information* policy described Beacon's procedures and guidelines for employees, contractors, and network providers for the uses and disclosures of protected health information (PHI). The policy stated that HIPAA permits the use and disclosure of PHI for treatment, payment, and healthcare operations and addressed additional protections for substance use disorder (SUD) information under 42 CFR Part 2. Staff members discussed that annual trainings are provided to employees and additional trainings are provided to specific departments that deal with more sensitive information to ensure that only the minimal amount of information is accessed by these employees.

HCI discussed its approach regarding educating staff members and the community about advance directives, including providing one-on-one meetings with members to provide information regarding advance directives. **HCI** offered an advance directive training to staff members, members, families, and the community. Staff members described the various channels through which **HCI** advertises its

trainings and discussed the call center associates' responsibilities in assisting and supporting community members with advance directives.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

HCI delegated the administrative and operational processes related to member information to Beacon. The *Member Information Requirements* policy discussed Beacon's processes to ensure that member informational materials are provided in plain language and are culturally and linguistically appropriate. During the review, staff members stated that **HCI** uses the Flesch-Kincaid method to ensure sixth-grade readability levels and described how the MEAC participates in testing the format and language of member informational materials.

Staff members discussed that **HCI** works to inform the State's eligibility technicians about **HCI** member information, as the eligibility technicians are often the first point of contact for members to understand their health plan benefits. **HCI** organized educational forums and had a Welltok texting campaign that is designed to help members understand the requirements and benefits of the plan. The *Welltok Monthly Report* detailed the texting campaign and analyzed successful outreach to different demographics. The text message scripts included different information, such as member handbook information, website link information, well-child visit reminders, the nurse advice line number, member rights, advance directives, vaccinations, behavioral health, crisis services, and how to get an insurance card. The **HCI** member website also contained information about the requirements and benefits of the plan including a video educating members about benefits.

HCI utilized the Department's *Brand Kit Index* and the *Health First Colorado Member Handbook* to ensure consistency in the information provided to members. Staff members stated that when a member is enrolled, the member receives the Department's welcome letter with **HCI**'s information. Staff members described the minimal mailing approach's intent is to reduce the influx of multiple member materials and to ensure consistency in information provided to the member. **HCI** submitted a *Managed Care Terminology* document that is used for consistency in definitions for managed care terminologies. **HCI** contracted with the Voiance® language service company to connect members with an interpreter in real

time and with the Asian Pacific Development Center to provide face-to-face, telephonic, or virtual interpretation in approximately 70 languages. Members were informed through the *Getting Started Flyer* and cover sheet that these services are available at no cost to the member.

The provider directories were available on **HCI**'s website in a machine-readable format. The provider directories included information about the provider's name, group affiliation, practice address and telephone number, website address, specialty, linguistic capabilities including American Sign Language (ASL), cultural competency training, whether providers are accepting new patients, and accommodations. In addition, **HCI** submitted a *Continued Access When Network Providers Discontinue Participation in Beacon's Network* document that described an automated process to update the provider directory monthly and that Beacon's provider relations team oversees the process to update the provider directory no later than 30 days from receipt of updated provider information.

Summary of Findings Resulting in Opportunities for Improvement

HCI submitted a *Website Compliance Check* document that demonstrates Beacon's effort to test for accessibility issues and Section 508 compliance. However, this document showed that some member-specific websites contained contrast error issues that did not meet the recommended threshold. HSAG conducted its own testing using the WAVE Web Accessibility Evaluation Tool and found that the provider directory webpage and member general webpage showed over 60 contrast error issues. HSAG recommends that **HCI** expand its procedures and reporting mechanisms to address, prioritize, and rectify contrast issues relating to accessibility and Section 508 compliance. HSAG recommends a review of **HCI**'s brand guidelines to accommodate for Section 508 compliance standards and consider the use of an Americans with Disabilities (ADA) widget on its webpages, if deemed helpful.

Summary of Required Actions

The *Member Information Requirements* policy described procedures for ensuring that member informational materials contain taglines that are consistent with the member information requirements. However, the cover sheet, welcome letter, *Getting Started Pregnancy Guide*, *Getting Started Flyer*, *HCI Brochure*, *EPSDT Tip Sheet*, *Care Coordination Fact Sheet*, and provider directory PDF did not include all the required components of a tagline. **HCI** must revise all critical member materials to include all required components of a tagline.

During the review, staff members reported that **HCI** received minimal ad hoc printing requests. Although, **HCI** submitted an email as evidence to show how **HCI** communicates internally to fulfill such requests, **HCI** could not provide supporting documents to demonstrate how **HCI** monitors the five-day requirements for such requests. **HCI** reported an opportunity to begin using a Microsoft (MS) Excel tracking mechanism to document timely mailing of ad hoc printing requests. **HCI** must develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost. Additionally, **HCI** is required to inform members that information provided electronically is available in paper form without charge upon request and is

provided within five business days. While this is noted in the general member webpage and provider directory webpage, the statement in the downloadable provider directory document did not include "within five business days." HSAG recommends that, as best practice, the statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page).

HCI used the Department's welcome letter and the *Health First Colorado Member Handbook* to inform newly enrolled members about services and to meet the requirements of 42 CFR §438.10. Although the welcome letter pointed members to the *Health First Colorado Member Handbook*, which included nearly all required information, the welcome letter distributed by the Department during CY 2021 did not contain **HCI**'s website address and neither did the *Health First Colorado Member Handbook*. Based on additional evidence in the form of email communications between **HCI** and the Department in July and November 2021, **HCI** was under the impression that the welcome letter used throughout FY 2021 contained website address details for each managed care entity. Based on this information, the requirement is considered met. The Department reported that an updated letter that will include the RAE's website address is estimated to go into production in July 2022; therefore, no required action associated with this finding is needed.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

HCI delegated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) administrative procedures to Beacon. Policies and procedures comprehensively addressed EPSDT services for members 20 and under and outlined the role of both behavioral health and PCMP providers within **HCI**'s network. The provider handbook and contract agreements further detailed the role of providers in screening, assessing, referring, and treating members based on medical necessity and EPSDT requirements. Beacon staff members in the call center and in care coordinator roles were available to coordinate appointments and transportation as needed or connect the member back with their PCMP, therapist, specialist, or local agencies as appropriate. Staff members described helping members with transportation frequently.

HCI generally informed members about EPSDT through the use of the Department's welcome letter, which directs the member to **HCI**'s website and associated welcome materials, including the *EPSDT Tip Sheet*, *Getting Started Flyer*, and well visit tip sheet. The *Health First Colorado Member Handbook* contained additional details about EPSDT, assistance with appointments, and transportation, and the *EPSDT Tip Sheet* linked to the Department-developed EPSDT materials and the *Bright Futures Guidelines*. EPSDT-eligible members received an automated interactive voice response (IVR) phone outreach, in either English or Spanish, with a brief message about included services within 60 days of enrollment. If the initial call was unsuccessful, one follow-up attempt occurred. Members with newborn children received a live "My Advocate" IVR call and as received an email or hard copy of information

following the telephone call. Where email addresses were available, **HCI** used the Constant Contact platform to send information.

For members who did not utilize EPSDT services in the course of a 12-month period, Beacon deployed text message reminders regarding the importance of well visits to members with mobile phone numbers on record that opted to receive text messages. Members could sign up for additional text messaging programs based on their interests.

HCI and Beacon staff members attended local formal and informal meetings to increase awareness about EPSDT; for example, Beacon staff members frequently attended county Department of Health Services meetings and Children's Disability Advisory Committee (CDAC) meetings in the region to further socialize EPSDT documents and resources. Staff members described efforts throughout CY 2021 to gain access to Head Start and Boys and Girls Club meetings due to identified overlap in membership needs.

Provider newsletters and regularly updated provider manuals served to inform the provider network about EPSDT trainings and updates every six months, and **HCI** engaged in regular behavioral health and SUD trainings that included EPSDT content. Providers had access to the *Care Coordination Referral Form* to request and submit necessary referrals, and Beacon staff members reported the ability to track the information in the electronic care coordination system.

Monitoring occurred through the use of Beacon's Chart Audit Tool and Care Coordination Audit Tools, which serve as a means to ensure that chart documentation, referrals, and services are sufficient to meet the members' healthcare needs. **HCI** and Beacon further demonstrated arranging and providing EPSDT services through a residential treatment report and encounter claims report, and utilization management staff members described known gaps in the provider network. In instances where access to needed services was limited, utilization management staff members described the ability to deploy intensive care management service in order to support the member while waiting for residential care. If a notice of adverse benefit determination is sent to the member, **HCI** reported that the notice includes EPSDT language.

Summary of Findings Resulting in Opportunities for Improvement

Quarterly outreach reports indicated a low success rate for completions; however, **HCI** described not including voicemails in this overall count. HSAG recommends verifying the definition of "completed" outreach with the Department and further exploring the addition of voicemails in upcoming quarterly outreach reports as a means to report a whole picture of **HCI** and Beacon's outreach efforts.

Summary of Required Actions

Although **HCI** generally informed the member of general EPSDT information, the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, **HCI** did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately one in every five members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021. **HCI** must:

- Update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits.
- Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 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 III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. 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, 2021, through December 31, 2021. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of 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.

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 D 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 2021–2022 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 VI—Grievance and Appeal Systems, 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.

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 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 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 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed 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.

Related to Standard VII—Provider Participation and Program Integrity, **HCI** was required to complete the following actions:

- Clarify in informational materials that while an individual provider may have objections, **HCI** as an organization does not.
- Update informational materials to reflect that when providers object to services, the member should be referred back to **HCI** to be assigned to a different provider if needed.

Related to Standard VIII—Credentialing and Recredentialing, **HCI** was required to complete the following actions:

- Update policy, processes, and procedures that demonstrate an ongoing review mechanism to ensure providers are not denied based on discriminatory reasons.
- Implement written processes to confirm that listings in practitioner directories are consistent with credentialing data, including education, training, and certification.

Related to Standard IX—Subcontractual Relationships and Delegation, **HCI** was required to complete the following action:

- Update the delegated credentialing agreements that did not include the detailed language specified in 42 CFR §438.230(c)(3) to meet this requirement.

HCI did not have any required actions for Standard X—Quality Assessment and Performance Improvement.

Summary of Corrective Action/Document Review

HCI submitted a proposed CAP in August 2021. HSAG and the Department reviewed and approved the proposed plan. Initial documents as evidence of completion were submitted in November 2021 and additional documents in December 2021. **HCI** resubmitted final CAP documents in January 2022.

Summary of Continued Required Actions

HCI successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefit,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social,	**Documents Submitted/Location Within Documents:** 1. R4_PopMangPln_FY20-21_HCI- entire document 2. R4_PopMangPln_FY20-21_HCPF Response_Accepted_HCI-entire document 3. R4_PopMangPln_FY21-22_HCI-entire document 4. R4_PopMangPln_FY21-22_HCPF Response_Accepted_HCI-entire document 5. ComplexCareDefinitionProposal_HCI-entire document 6. R4_ApprovalLetterforComplexProposalApproval_HCI-entire document 7. CareCoordinationGeneralPolicy_HCI-entire document 8. R4-262L_CareCoordinationPolicy_HCI-entire document 9. CareCoordinationPlan_HCI-entire document 10. QM33.9CulturalCompetencyPolicy_HCI-entire document 11. PhysicalHealthProviderHandbook_HCI -pages 20-21, 26-30.*Misc. 12. BehavioralHeatlhProviderHandbook_HCI - pages 20, 56-57, *Misc. 13. PCMPAccountableAgreement_HCI-pages 15-23, Exhibit B and C *Misc. 14. CareCoordinationSIPOC_HCI-entire document 15. CareCoordinationAuditPlan_HCI-entire document 16. CareCoordinationAuditTool_HCI-entire document **Description of Process:** Health Colorado Inc. (HCI) as the Regional Accountable Entity (RAE) implements procedures to deliver care to and coordinate services for all members, and demonstrates this in the following documents:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 7: Exhibit B6—11.3.1, 11.3.7	**R4_PopMangPln_FY20-21_HCI - entire document.** This Population Health strategic plan was active during the first half of 2021. Pages 2-4 overview the main categories of risk stratified care management framework. Page 5 addresses HCI's care coordination intervention model. The initial value streams were completed in conjunction with Health Colorado staff and the consultants hired to facilitate the initial process. The information gathered in these initial value streams informed the areas of focus identified in the next Population Health Strategic Plan (R4_PopMangPln_FY21-22) submitted July 1, 2021. **R4_PopMangPln_FY21-22_HCI-entire document**: The population health plan supports care coordination at the place of care and/or from an existing trusted and local provider, as a critical intervention that is available to all Members in R4. Care coordination is considered integral to HCI's Population Health Framework, encompassing both Care Navigation and Care Management. This work is especially highlighted in Strategy 2: Transform our Care Delivery System, and Element #4: Addressing the health care needs of members with complex needs; Element #5: Management and prevention of conditions that impact members; Element #7: Transformation of Care Coordination; and Element #8: Enhance Health Neighborhood. Care Coordination is an intervention that connects our members and engages them in the resources available is a key intervention to managing our population's health overall. Reliably identifying those members most likely to benefit from specific interventions is	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	paramount to the efficiency of a care management infrastructure. HCI's stratification process has evolved over time as population health best practices and stratification methodology algorithms have improved. During the course of this audit period, HCI has utilized HCPF's definition of complex members, which is members who have $25,000 or more in cost of care over a rolling twelve (12) month period. HCPF classifies members into different strata, which typically results in three (3) main categories: • *Advanced Illness:* This refers to members that need complex case management • *At-risk, Multiple or Poorly Controlled Chronic Conditions:* This category is for members with chronic conditions who may be at risk of developing or progressing into advance illness (complex case) • *Healthiest Low Utilizing Members:* These are members who do not have any chronic conditions, those that have some acute conditions, or those who may not be utilizing care. The department response to the population health plans are also attached which were accepted (**R4_PopMangPln_FY20-21_HCPF Response_Accepted_HCI-entire document, and R4_PopMangPln_FY21-22_HCPF Response_Accepted_HCI-entire document**). **ComplexCareDefinitionProposal_HCI-entire document**: Health Colorado Inc. (HCI) submitted the following proposal in alignment with the Department's support of individual RAE efforts to establish their own innovative and evidence-	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	based risk stratification methodologies for complex members. HCI requested and was granted permission to implement an alternative definition of "complex," outlined in the following brief proposal to the Department. The department response to the complex member definition proposal is also attached (**R4_ApprovalLetterforComplexProposalApproval_HCI-entire document**). This proposal was submitted and approved of during the audit period of 2021 but will not be implemented until 2022. **CareCoordinationGeneralPolicy_HCI-entire document** adheres to this requirement and identifies the Delegated Care Coordination Entity is responsible for coordinating all aspects of the members care, including the medical treatment team, specialty care and any other health providers involved in the member's care. Care coordination provided at the point of care whenever possible, is culturally responsive and provided for both short and long-term healthcare needs. Member preferences are respected and regular communication between care coordinators and the practitioners delivering services to members provided. This policy has evolved over time in response to requests for streamlined expectations and simplicity as well as changes to the Department's complex care coordination strategy, extended care coordination (ECC) performance pool metric and complex care coordination definition. The previous care coordination policy **(R4-262L_CareCoordinationPolicy_HCI-entire document)**, and the previous care coordination plan **(CareCoordinationPlan_HCI-entire document)** were	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	active from 1/1/2021-9/28/2021 at which point they were combined into a singular care coordination policy and approved on 9/29/2021. This policy was disseminated to our care coordination entities via the monthly care coordination meeting on 10/6/2021, and attached to meeting minutes for all participants. Our current policy (**CareCoordinationGeneralPolicy_HCI-entire document**) addresses all components of this requirement, including that it: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. This policy provides an overview of comprehensive care coordination services for members of the RAE. This policy is	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	intended to provide guidance about the scope of care coordination activities, yet it must be acknowledged that the service needs for individual members can vary widely and the specific processes for care coordination may vary, depending upon the type of treatment setting and the staff that are assigned care coordination responsibilities. Members may receive care coordination services through the RAE, or through its partners/providers. Service settings may include individual primary care practices, group medical practices, specialty care settings, behavioral health care settings, including community mental health centers, Federally Qualified Health Centers, and other locations. The RAE works to provide education, monitoring, reporting, training, and communication. This policy identifies the Delegated Care Coordination Entity is responsible for coordinating all aspects of the members care, including the medical treatment team, specialty care and any other health providers involved in the member's care. Care coordination is accessible to all members, by provider referral, self-referral, or care coordinator referral. Instructions on how to access care coordination is provided via information sharing at external meetings, call center, website, PCMPs, CMHCs, etc. Care coordination provided at the point of care whenever possible, is culturally and linguistically responsive and provided for both short and long-term healthcare needs. Member preferences are respected and regular communication between care coordinators and the practitioners delivering services to members provided. Care Coordinators ensure that physical, behavioral, long-term care, social and other services are integrated, continuous, and comprehensive and the service	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers communicate with one another in order to effectively coordinate care. Care coordinators provide services that are not duplicative or other services and that are mutually reinforcing. Care Coordination activities are documented, for both medical and non-medical activities. Care coordination shall be provided in alignment with RAE principles. These principles include ensuring that physical, behavioral, long-term care, social and other services are integrated, continuous, and comprehensive and the service providers communicate with one another in order to effectively coordinate care. **QM33.9CulturalCompetencyPolicy_HCI-entire document** underscores the commitment to developing and implementing policies and procedures that will enhance cultural competency; to breaking down barriers to access and utilization that are faced by many minorities when seeking behavioral health care. These barriers include relevancy of services and financial, language, transportation and literacy barriers; to broadening multi-cultural participation in our provider network; to promoting the ethic of cultural competence and educating our staff, providers, partners, members and the community about member's rights to culturally competent services. **PhysicalHealthProviderHandbook_HCI, Cultural Competency Section pages 20-21** identifies that the regional organization requires all physical, behavioral health and care coordination services are provided in a culturally competent manner. This includes sensitivity to the member's particular	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	language needs and their cultural beliefs and values. **PhysicalHealthProviderHandbook_HCI, Care Coordination Section pages 26-30** identifies expectations for providers as it relates to Care Coordination, regional strategy, the care coordination delegation model, provider role as it relates to care coordination and care coordination principles. **BehavioralHealthProviderHandbook_HCI, page 20-** Participating providers should identify all providers/participating providers involved in the medical and/or behavioral health care and treatment of a member. All coordination, including PCMP coordination, should be documented accordingly in the member treatment record. The sectional also provides tips to improve care coordination communication. The **BehavioralHealthProviderHandbook_HCI** on **pages 56-57** in the Cultural Competency Section identifies that the regional organization requires all physical, behavioral health and care coordination services are provided in a culturally competent manner. This includes sensitivity to the member's particular language needs and their cultural beliefs and values. **PCMPAccountableAgreement_HCI-pages 15-23, Exhibit B and C** identifies requirements of the Care Coordination Delegated Entities. We work to improve care coordinators knowledge through ongoing trainings/meetings regarding contract requirements. We have monthly care coordination subcommittee meetings	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with Delegated Care Coordination Entities from across the region. Delegated Care Coordination Entities also participate in regular Quality Improvement work through Lean Process Improvement efforts. See **CareCoordinationSIPOC_HCI** as an example of this work. Care coordinators are monitored on compliance with the entirety of requirement 1 through existing audit and performance improvement procedures. See **CareCoordinationAuditPlan_HCI-entire document,** and **CareCoordinationAuditTool_HCI-entire document** to address this requirement.	
2. The RAE ensures that each *behavioral health member* has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact their designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. CareCoordinationGeneralPolicy_HCI-entire policy 2. CareCoordinationAuditTool_HCI -Section 3 3. PhysicalHealthProviderHandbook_HCI, Page 26-28*Misc. 4. BehavioralHealthProviderHandbook_HCI, page 38*Misc. 5. CareCoordandBHProviders_HCI- entire document 6. Policy210L_MemberRoutineRequest_HCI – entire policy 7. HCPFWelcomeLtr_HCI *Misc 8. WelcomeMemberLetter_HCI-entire document 9. Getting Started Flyer_HCI, *Misc 10. Getting Started PPT_HCI *Misc. 11. HCIWelltokWelcomeCampaignMessages_HCI-entire document 12. Care Coordination Fact Sheet_HCI *Misc 13. 307L_MemberInfoReqPolicy_HCI –entire document, *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: We initiate this process internally by providing each of the care coordination entities in Region 4 with a list of designated members assigned to them. The member's "Member ID" (Medicaid ID) is bumped up to the 834-member eligibility dataset to confirm that the member is eligible within the RAE. Once complete, a set of queries assigns a Care Coordinator to the members based off of PCMP location. The assignment lists are then sent out to the Care Coordinators via secure email or through File Connect. We also provide care coordination information to members on the website (https://www.healthcoloradorae.com/members/care-coordination/) & have a designated care coordination phone number listed under the "Contact" tab on the website (https://www.healthcoloradorae.com/contact/). Members who utilize the contact information are routed to their assigned care coordination entity as needed. **CareCoordinationGeneralPolicy_HCI -page 5** speaks to care coordinators ensuring proper coordination with medical and behavioral health providers and access to community resources. This also addresses the assessment of the member's needs for services and coordinating services rendered by multiple providers functioning as the single point of contact with the different systems related to the member. Care coordination delegated entities are monitored on compliance with this requirement through existing audit	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	procedures. See **CareCoordinationAuditTool_HCI** -Section 3 Care Team. PhysicalHealthProviderHandbook_HCI. , Page 26-28 articulates that accountable PCMPs/ Delegated Care Coordination Entities will manage the member's physical and behavioral health needs as well as collaboration with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex member needs spanning multiple agencies. **BehavioralHeatlhProviderHandbook_HCI, page 38** details coordination with all treating providers and tips to improve care coordination. Beacon Health Options care management team also conducts coordination of care activities in the following situations, Members and participating behavioral health providers may access the Beacon care management system through any of the following avenues: 24-hour toll-free emergency care/clinical referral line, direct registration/certification of care through ProviderConnect for participating providers, direct authorization/certification of all levels of care through referral by a Beacon Clinical Care Managers (CCM), emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms, or crisis response teams. If a call is received from a member requesting a referral and/or information about participating behavioral health providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating behavioral health providers, taking into account member preferences such as	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating behavioral health providers holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location, and phone number of at least three participating behavioral health providers will be given to the member. **Policy210L_MemberRoutineRequest_HCI** entire policy. All member requests are handled expeditiously. Each member attempting to access care directly or by a representative through any Beacon Health Options 24 hour Clinical Referral/Direct line is assessed for risk of self-harm, harm to others, or harm by others and referred to the appropriate level of care. The member is given information related to Network Providers/Care Coordination Entities including providers' names, addresses and phone numbers in attempt to link with services. Behavioral health providers are educated on HCI's delegated care coordination structure, the importance of care coordination, care coordination role with behavioral health providers and how to link members with care coordination using the **CareCoordandBHProviders_HCI** document. A Welcome Letter from The Department of Health Care Policy and Finance (HCPF) with a url link to HCI's website is sent to members (See **HCPFWelcomeLtr_HCI**). HCI has a	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	New Member Welcome Packet which includes HCI's welcome letter as well as other resources (https://www.healthcoloradorae.com/members/new-member-welcome-packet/) see **WelcomeMemberLetter_HCI.** HCI hosts a "Getting Started" webinar on the first Thursday of every month to orient members to their benefits, how to use them and how to get help finding resources (See **Getting Started Flyer_HCI** and **Getting Started PPT_HCI**). **HCIWelltokWelcomeCampaignMessages_HCI** document outlines text messages sent out to members enrolled in this campaign covering topics such as how to contact the health plan, accessing the member handbook and member rights, how to get a new ID card as well as benefit reminders such as well visits, immunizations, mental health and dental. Through these messages, members are also provided information to access care coordination, connection to community resources and crisis services. Members are provided information regarding what care coordination is, how it works with their care, that it is free and if a member wants a care coordinator how to request one using the **Care Coordination Fact Sheet_HCI**. The tip sheet was distributed to care coordinators, practice transformation coaches, member advocates and was uploaded to the HCI website (https://www.healthcoloradorae.com/members/care-coordination/).	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The document titled **307L_MemberInfoReqPolicy_HCI (entire policy)** establishes guidelines for the development and distribution of critical member information and mechanisms in place to help members understand the requirements and benefits of their plan in plain language.	
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 7: Exhibit B6—6.8.1	**Documents Submitted/Location Within Documents:** 1. AttributionClaimsDataValidationProcess_HCI-entire document 2. PCMP Data Management Procedure_HCI – entire document 3. PhysicalHealthProviderHandbook_HCI - Page 23-24 *Misc. **Description of Process:** The RAE compares the Department's attribution and assignment list with Member claims activities to ensure accurate attribution/assignment. The RAE also completes follow-up with members to identify barriers accessing PCMP's within the region and assist with changing the attributed PCMP when appropriate. This is demonstrated in the following processes: **AttributionClaimsDataValidationProcess_HCI**: the entire document outlines the standard operating procedure to verify the attribution list provided by the Department of Health Care Policy and Finance (HCPF) is aligned with claims activity to ensure members are being assigned to providers in which they	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	have an active relationship with. Once this process is complete, we provide the list of outliers to the care coordination entities for follow-up to assess for any barriers, as well as to assist with contacting the enrollment broker for reattribution. **PCMP Data Management Procedure_HCI** the entire document outlines the standard operating procedure for tracking information necessary to provide network reporting for Primary Care Medical Providers (PCMP). The described procedure in the document is how HCI accurately documents and tracks the contracted providers to receive the member attribution lists. Provider Relations Department ensures all contracted PCMPs by Billing ID are affiliated with the RAE, make any additions, changes or deletes on monthly basis as appropriate. This includes closing or opening panels for new members or geo attribution. Provider relations department works with internal data analysts to confirm the correct PCMPs by Billing ID while Data Analytics and Reporting (DAR) conducts a crosscheck of the attribution and assignment to identify any peculiar attribution (i.e. a non-contracted PCMP has attributed members). Provider relations department works with PCMPs if they report issues with attribution and forward to HCPF for panel analysis and resolution. This can include PCMP reporting members with claims history not being attributed to them. PhysicalHealthProviderHandbook_HCI - **Page 23-24** – Describes the member attribution process for PCMP providers as well as how a member can change their PCMP	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and how PCMPs can check the eligibility of members via the state portal.	
4. The RAE's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extended assistance and include appropriate interventions. Contract Amendment 7: Exhibit B6—11.3.3	**Documents Submitted/Location Within Documents:** 1. CareCoordinationGeneralPolicy_HCI- pages 1-3, and pages 10-11 2. R4-262L_CareCoordinationPolicy_HCI-pages 1-3 3. CareCoordinationPlan_HCI-pages 1-3 4. PhysicalHealthProviderHandbook_HCI -page 27*Misc. 5. PCMPAccountableAgreement_HCI-pages 22-23*Misc. 6. ComplexCareDefinitionProposal_HCI-entire document 7. R4_ApprovalLetterforComplexProposal_HCI-entire document 8. CareCoordinationAuditTool_HCI-entire document 9. CareCoordinationAuditPlan_HCI-entire document **Description of Process:** The RAE ensures care coordination will be accessible to all members. Care coordination is comprised of deliberate interventions as well as extended care coordination. Deliberate interventions are available to the broader population and include tactics such as medical and social referrals, telephonic/electronic communications, educational resources, etc. Extended care coordination is targeted to specific complex member groups who require more intense and prolonged assistance and includes interventions such as care planning, face-to-face visits, etc. **CareCoordinationGeneralPolicy_HCI- pages 1-3, and pages 10-11** adheres to this requirement. This policy has	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	evolved over time in response to requests for streamlined expectations and simplicity as well as changes to the Department's complex care coordination strategy, extended care coordination (ECC) performance pool metric and complex care coordination definition. The previous care coordination policy **(R4-262L_CareCoordinationPolicy_HCI-pages 1-3)**, and the previous care coordination plan **(CareCoordinationPlan_HCI-pages 1-3)** were active from 1/1/2021-9/28/2021 at which point they were combined into a singular care coordination policy and approved on 9/29/2021. This policy was disseminated to our care coordination entities via the monthly care coordination meeting on 10/6/2021, and attached to meeting minutes for all participants. Our current policy (**CareCoordinationGeneralPolicy_HCI-pages 1-3, and pages 10-11**) addresses all components of this requirement, including that care coordination is defined as identifying the needs of members and/or family members/caregivers, especially those with complex care needs, chronic conditions, and preventative measures, as well as provide them with the care and resources that meet these needs. This includes physical health, behavioral health, functional Long Term Services and Supports (LTSS) supports, oral health, specialty care, social determinants of health and other services. It is sub-divided into care navigation and care management. Care navigation entails removing the barriers that members may encounter when accessing care and connecting them with the services and resources that they need. Care management involves a much more hands on approach, supporting members with complex	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care needs and chronic conditions by ensuring they get the care they need and they are engaged with the care process to improve their health outcomes. Deliberate Care Coordination is defined as a task-oriented care coordination activities such as connection to transportation services. On pages 10-11, the policy documents specific elements of care coordination care plans that adheres to this requirement. The Care Plan includes a highly individualized range of interventions to help members, their families and caregivers manage serious and complex conditions that are persistent and substantially disabling or life threatening. Identified deliberate care coordination efforts and frequency are documented. Development and oversight for Extended Care Coordination activities are identified in the Care Plan. There are ten (10) specific conditions identified by the Department that require coordination of multiple health services to support the maintenance of health and prevent disease progression. Delegated Care Coordination Entities will include the management of these conditions as part of their individualized integrated whole person care plan: 1. The contractor must engage Complex members in an evidence-based condition/disease management program based upon the Complex member's condition(s). 2. The chronic condition/disease management programs are to be defined by the PCMP in conjunction with HCI, documented by the PCMP and provided to Beacon for each chronic condition identified by the Department in the Complex member data set. 3. Each Complex member has an identified strategy based upon their condition(s) which will both improve quality	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	metrics and reduce their total cost of care, and which will be verified through chart audits by Beacon of the PCMP's care coordination encounters with the strategy identified in the Care Plan. 4. Complex care management interventions will include chronic condition management education as appropriate as well as assistance with accessing care across the continuum for as long as necessary to stabilize or impact care outcomes. PhysicalHealthProviderHandbook_HCI **page 27** outlines that accountable PCMP's/delegated care coordinators will provide both deliberate and extended care coordination services. It then defines deliberate and extended care coordination activities per definitions in care coordination policy above. **PCMPAccountableAgreement_HCI-pages 22-23** outlines expectations of deliberate and extended care coordination. **ComplexCareDefinitionProposal_HCI-entire document**: HCI submitted this proposal to implement an alternative definition of "complex," outlined in the following brief proposal to the Department. The department response to the complex member definition proposal is also attached (**R4_ApprovalLetterforComplexProposal_HCI-entire document**). This proposal was submitted and approved of during the audit period of 2021 but will not be implemented until 2022. In alignment with the Department's timeline, activities targeted to these specific members who require more intense and extended assistance and include appropriate interventions will be aimed at this newly defined complex cohort, thus further differentiating the difference between	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	deliberate and extended care coordination moving into the future. **CareCoordinationAuditTool_HCI**-entire document and **CareCoordinationAuditPlan_HCI**-entire document addresses both short and long-term health needs. Ensures care coordination documentation for developing and maintaining comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational programs, and other agencies that serve special populations. Care Coordination documentation for linking members to both medical and non-medical, community-based services, such as child care, food assistance, elder support services, housing, utilities assistance, and other non-medical supports. Shows proof of delegating care coordination duties to designated staff persons to function as the single point of contact with the different systems and settings related to the member; Designating staff persons have the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population; Are providing specific guidance to care coordinators about each setting, regarding how to identify members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and member concerns.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 7: Exhibit B6—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 14.3	**Documents Submitted/Location Within Documents:** 1. 282L_Transitions of Care-BH_FY21-22_HCI- Entire Policy 2. 254L_TransitionandContinuityofCare_HCI- Entire Policy 3. CareCoordinationGeneralPolicy_HCI – page 9 4. CareCoordinationAuditTool_HCI -entire document 5. Complex Care Deliverable SFY21-22Q1_HCI- Entire Document 6. DOC Member Welcome letter_HCI- Entire Document 7. HealthFirstCO Member Handbook_HCI- Entire Document 8. DOC Dental Benefit_HCI- Entire Document 9. BehavioralHeatlhProviderHandbook_HCI - Page 52 *Misc. **Description of Process:** The RAE administers the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the work outlined in the contract thereby creating a seamless experience for members and providers, as evidenced by the following documents. **282L_Transitions of Care-BH_FY21-22_HCI** and **254L_TransitionandContinuityofCare_HCI :** It is the policy of the Colorado Springs Engagement Center (COS_EC) to assist Members in transitioning from one system of care to another with minimal disruption in their behavioral health services. This policy ensures that members with special health care needs have continued access to services during a transition from one system of care to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	another. These policies are aligned with the requirements of 42 CFR 438.62 and the Colorado Department of Healthcare Policy and Financing's (HCPF) Transition of Care Policy. **CareCoordinationGeneralPolicy_HCI – page 9,** outlines the expectations of care coordinators with members who are undergoing transitions of care between settings of care. If the enrolled member is seen in an emergency room or is admitted to an inpatient facility, upon notification of this information, the Delegated Care Coordination Entity follows up with the member within the specified timeframe. The Delegated Care Coordination Entity also assists members with moving between service settings to ensure that the member is placed in or remains at the most appropriate, least restrictive setting that meets the member's needs, and conducts appropriate discharge planning. Care coordinators are monitored on compliance with this through existing audit and performance improvement procedures. See **CareCoordinationAuditTool_HCI-entire document** to address this requirement. **Complex Care Deliverable SFY21-22Q1_HCI-** Entire Document**:** HCI members who transition between healthcare or social settings are captured in our Complex Care programing. HCI complex care membership consists of a small group of members who do cycle through multiple healthcare and social support systems. HCI utilizes community-based care coordination entities to provide care management and systems of care navigation, including transitions between specialty care, acute care, acute care,	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	foster care, and correctional institutions. HCI also utilizes our Clinical Care Management for members who have multiple agencies coordinating their care. Collaborative efforts and partnerships with Colorado's Single Entry Points (SEP), Community Centered Boards (CCB), and Long-term home health (LTHH) agencies support outreach and engagement of members under their care. **DOC Member Welcome letter_HCI**- Entire Document: HCI has excelled with our work supporting our justice-involved members who are transitioning out of a prison facility. The Welcome letter is part the first in the Welcome Packet used during our face-to-face in-reach program. Each member is identified 90-days to their release date and our face-to-face engagement happens prior to member releasing back to the community. **HealthFirstCO Member Handbook_HCI** (entire document)- second the Colorado Health First Member Handbook is issued to our members who engage with the HCI In-Reach program. They each participate in an educational seminar, which goes over in detail the sections of the Member Handbook, while also discussing their criminogenic needs. **DOC Dental Benefit_HCI**- Entire Document: third The Colorado DentaQuest benefit is also shared with our justice involved members prior to their release. **BehavioralHeatlhProviderHandbook_HCI - Page 52** - The continuity and coordination of care throughout HCI's	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	continuum of behavioral health services is monitored. Which may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to: • A member requires a change in level of care, necessitating a new participating provider • There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for ongoing treatment) • A change in health plans or benefit plans • Termination of a participating provider • A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in developmental disabilities) Subject to any member consent or authorization required by applicable state and/or federal laws and/or regulations, participating providers should coordinate care as appropriate, sharing information with other treating providers/participating providers within the context of providing quality care and	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	within the guidelines of protecting a member's privacy and confidentiality.	
6. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or RAE. *42 CFR 438.208(b)(3)* Contract Amendment 7: Exhibit B6—7.5.2–3	**Documents Submitted/Location Within Documents:** 1. HealthNeedsSurveyProcess_HCI-entire doc 2. PCMPAccountableAgreement_HCI- Exhibit B page 16 *Misc. 3. R4-262L_CareCoordinationPolicy_HCI - Page 2, 4 **Description of Process:** The RAE uses the results of the Health Needs Survey, provided by the Department, to inform member outreach and Care Coordination activities. The RAE processes a daily data transfer from the Department to retrieve the HNS results for distribution to attributed care coordination entities. This can drive member outreach and care coordination activities. **HealthNeedsSurveyProcess_HCI**- entire document describes the process of intake and distribution of the Health Needs Survey (HNS). The File Utilization Batch System (FUBS) Application runs on an automated schedule to download the Health Needs Surveys. FUBS will look for any new HNS that are made available on the Secure File Transfer Protocol (SFTP) site. Once FUBS finds a new file, the file is downloaded to a file repository on the server. The file is then processed to the Colorado data warehouse under the [RAE4].[dbo].[HealthNeedsSurvey] database structure. All Health Needs Surveys are appended to this database.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The member's "MemberID" (Medicaid ID) in the HNS is bumped up to the 834-member eligibility roster dataset to confirm that the member is eligible within the RAE. The HNS does not have the member demographics such as phone and address. This information is pulled from the 834-member eligibility dataset roster and is appended to the HNS database. Once the member's demographics have been included in the HNS dataset, a set of queries assign a Care Coordinator to the members based off of PCMP location. The reports are then sent out to the Care Coordinators via secure email or through FileConnect. **PCMPAccountableAgreement_HCI- Exhibit B page 16**- reinforces expectations for the care coordination entity to use the results of health risk assessment and needs assessments and any condition specific assessments to inform member outreach and Care Coordination activities. The **R4-262L_CareCoordinationPolicy_HCI, page 2, 4** define the Health Needs Survey (See **page 2**), and how care coordinators are to use the results of the ADT, Health Needs Survey, COUP and Nurse Advice Line, provided by the Department, to inform member outreach and Care Coordination activities (See **page 4**).	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Behavioral Health Benefit:* The RAE ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems *42 CFR 438.208(c)(2-3)* Contract Amendment 7: Exhibit B6—14.7.1	**Documents Submitted/Location Within Documents:** 1. ChartAuditTool_HCI - Entire Document *Misc. 2. Provider Documentation Training_HCI -Entire Document*Misc. 3. 282L_Transitions of Care-BH_FY21-22_HCI- Entire Policy 4. BehavioralHeatlhProviderHandbook_HCI – Page 34, 52-54 *Misc. 5. PhysicalHealthProviderHandbook_HCI - Page 27-28*Misc. 6. QM 16B Provider Treatment Record Review Analysis and Reporting_HCI -entire policy 7. Audit Policy_QM16.24_HCI- entire document 8. R4_PopMangPln_FY21-22_HCI- Page 6 9. A3_CareNav_IntakeAsmt_HCI – Entire Document **Description of Process:** Based on the member's needs and level of care required, the RAE ensures procedures for the following: each member receives an individual intake and assessment appropriate for the level of care needed, and a service planning system that uses the information gathered in the member's intake and assessment to build a service plan. Providers are monitored on compliance with this requirement through existing audit procedures (see **ChartAuditTool_HCI).** Specifically auditing the intake assessment and treatment planning requirements. Providers receive training on these requirements as outlined in **Provider Documentation Training_HCI** (Entire document).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	It is the policy of Beacon Health Options to assist Members in transitioning from one system of care to another with minimal disruption in their behavioral health services. This policy ensures that members with special health care needs have continued access to services during a transition from one system of care to another. This policy is aligned with the requirements of 42 CFR 438.62 and the Colorado Department of Healthcare Policy and Financing's Transition of Care Policy (**282L_Transitions of Care-BH_FY21-22_HCI-Entire policy)**. Behavioral health providers/participating behavioral health providers must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process (see **BehavioralHeatlhProviderHandbook_HCI – Page 34**). CCMs review the treatment plans with the behavioral health providers/participating behavioral health providers to ensure that they include all elements required by the provider agreement, applicable government program, and at a minimum include the following: • Specific measurable goals and objectives • Reflect the use of relevant therapies • Show appropriate involvement of pertinent community agencies • Demonstrate discharge planning from the time of admission	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Reflect active involvement of the member and significant others as appropriate Behavioral health providers/participating behavioral health providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate. Continuity and coordination of care is monitored through the continuum of behavioral health services (See **page 52**). Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to: • A member requires a change in level of care, necessitating a new participating provider • There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for ongoing treatment) • A change in health plans or benefit plans • Termination of a participating provider • A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	specialists, or providers specializing in developmental disabilities) The "Treatment Record Standards and Guidelines" (see **BehavioralHeatlhProviderHandbook_HCI Page 52-54**) section outlines how member treatment records should be maintained, as well as what should be included in the progress notes, and record-keeping standards for treatment record reviews and audits. Compliance with these standards of care are monitored through treatment record reviews, audits and associated requests for copies of member records. The document titled **PhysicalHealthProviderHandbook_HCI - Page 27-28**, states that "All accountable PCMPs/Delegated Care Coordination Entities are responsible for completing an assessment with the member to determine medical and non-medical needs in order to link members to appropriate resources." Following the comprehensive member assessment, care coordination activities are structured by a clinical care plan, a collaborative, living document generated by the member and care coordinator reflecting member's needs, log and short-term goals, associated resources, supports, providers and action steps toward reaching their identified goals. **QM 16B Provider Treatment Record Review Analysis and Reporting_HCI-** The entire policy covers review of behavioral health practitioner treatment records to evaluate compliance with the treatment record documentation	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	standards and to monitor adherence to clinical practice guidelines, as part of continuous quality improvement and/or monitoring activity. All providers are required to maintain records in compliance with standards, and the State of Colorado standards, which require that "member treatment records are maintained in a manner and includes current, comprehensive, detailed, organized, and legible writing and/or electronic organization to promote effective member-care and quality record review process" (page 1). Treatment records are subject to audit/reviews by the State of Colorado, Beacon's Clinical and/or Quality Management/Compliance Departments and accrediting bodies. Provider participation is an integral part of HCI's quality improvement program and is a condition of network participation. The purpose of the document titled **Audit Policy_QM16.24_HCI** (Entire document) is to have processes in place for treatment record reviews in order to monitor practitioner/provider/facility performance, to determine if this has resulted in positive outcomes for members, and to ensure adherence to the treatment record standards and guidelines as documented in the Provider Handbook (see **BehavioralHeatlhProviderHandbook_HCI Page 52-54**). In alignment with HCI's Population Health Strategy (**R4_PopMangPln_FY21-22_HCI- Page 6**), Strategy #2 Transform our Care Delivery System, Element #4 Addressing the Health Care Needs of Members with Complex Needs, we completed an A3 (**A3_CareNav_IntakeAsmt_HCI- Entire**	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Document) to develop and pilot a standardized intake assessment in the Care Coordination platform, Essette. The standardized intake assessment combined both the PRAPRE and WMI assessments as well as contract requirements for an intake assessment into one assessment. The intake assessment then went through two rapid experiment Plan Do Study Act (PDSA) cycles with one of the care coordination entities to pilot it before releasing the intake assessment for use to all care coordination entities. The impact of the PDSA was measured according to the Benefit Measurement plan process measures (See **A3_CareNav_IntakeAsmt_HCI - Entire Document**). The outcome measures will be evaluated over the upcoming year.	
8. *For the Capitated Behavioral Health Benefit:* The RAE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. CareCoordinationGeneralPolicy_HCI-pages 5-8, 10 2. R4-262L_CareCoordinationPolicy_HCI-pages 2-5 3. CareCoordinationAuditTool_HCI-entire document 4. CareCoordinationAuditPlan_HCI-entire document 5. PCMPAccountableAgreement_HCI-pages 4, 6, 18 *Misc. 6. R4_narrative_CareCompacts_Q4FY21_HCI-entire document 7. R4_CareCompactQ4_FY20-21_HCI-entire document 8. SolvistaHealthandHealthTrac_CareCompact_HCI-entire document **Description of Process:** The RAE has established and strengthened relationships among Network Providers and the Health Neighborhood in the region by supporting existing collaborations and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts. Care coordination expectations directly align with this requirement. Beacon sends monthly lists to Delegated Care Coordination Entities. These lists include PCMP identification, so that Delegated Care Coordination Entities can efficiently engage in two-way communication between care coordinators and PCMP's to ensure member's needs are met. Care coordinators continually work on improving bidirectional communication processes with member PCMP's. Beacon ensures that all care coordination, including interventions provided by Network Providers and Subcontractors meet the needs of the member. Beacon provides additional support and guidance when the systems and providers engaged with a member's complex care require leadership and direction. **CareCoordinationGeneralPolicy_HCI- pages 5-8, and pages 10** adheres to this requirement. This policy has evolved over time in response to requests for streamlined expectations and simplicity as well as changes to the Department's complex care coordination strategy, extended care coordination (ECC) performance pool metric and complex care coordination definition. The previous care coordination policy **(R4-262L_CareCoordinationPolicy_HCI-pages 2-5)** was active from 1/1/2021-9/28/2021 at which point it was updated and approved on 9/29/2021. This policy was disseminated to our Delegated Care Coordination Entities via the monthly care coordination meeting on 10/6/2021, and attached to meeting	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	minutes for all participants. Our current policy (**CareCoordinationGeneralPolicy_HCI-pages 5-8, and pages 10**) addresses all components of this requirement. Care coordinators are required to reach out and connect with other service providers not limited to medical and behavioral health providers as well as access to community resources for all members. The goal is to communicate information appropriately, consistently, and without delay. Member preferences will be respected and regular communication between Delegated Care Coordination Entities and the practitioners delivering services to members will be provided. The Delegated Care Coordination Entity is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health services rendered by multiple providers, coordinating behavioral health services with other health care and human service agencies and providers, and referring to other health care and human service agencies and providers, as appropriate. The care coordinator will share the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste and abuse. Delegated Care Coordination Entities will coordinate with the member's healthcare providers to facilitate delivery of services as appropriate and make reasonable efforts to assist individuals to obtain medically necessary services. If a member is having difficulty arranging for medical/behavioral health care, the Delegated Care Coordination Entities will assist and make an appointment for the member, if needed. Care coordination shall be provided in alignment with RAE principles. These principles include:	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Ensuring that physical, behavioral, long-term care, social and other services are integrated, continuous, and comprehensive and the service providers communicate with one another in order to effectively coordinate care. • Ensuring that care is coordinated within a practice, as well as between the practice and other providers and organizations serving a member. • Provide services that are not duplicative or other services and that are mutually reinforcing. Shall not duplicate Care Coordination provided through LTSS or Home and Community Based Service waivers and other programs designed for special populations; rather, will work to link and organize the different Care Coordination activities to promote a holistic approach to a member's care. Care Coordinators shall maintain relationships with community organizations such as specialty care, managed service organizations and their networks of substance use providers, hospitals, pharmacists, dental, nonemergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers. Develop and maintain comprehensive knowledge and working relationships with community agencies, health teams and providers that offer a range of services including medical care, substance abuse and mental health treatment, legal services, long-term care, dental services, developmental disability services, homeless services, school and educational	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	programs, and other agencies that serve special populations. Delegated Care Coordination Entities will coordinate services and share relevant treatment information with the following groups or parties, as appropriate, with the consent of the member. This policy does not require the provider to coordinate with all of these groups or to document when or why a particular group is excluded; it only requires the provider to coordinate with these entities, when it is clinically appropriate to do so: • Providers of primary care • Any other Managed Care Organization • Other behavioral health providers • Other physical health care providers to include specialty care • Long-term supportive services and providers including private duty nursing, long term home health, long term care facilities, and assisted living facilities • Waiver service providers • Pharmacies and pharmacists • County and State agencies • Other provider organizations that provide wraparound services • The single entry point (SEP) organization or care manager • Other parties as required by HCPF • Colorado Crisis System	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Finally, care coordinators are required to coordinate with other healthcare providers for diagnostics, ambulatory care, and hospital services. Delegated Care Coordination Entities will assist in PCMP referral and attribution, as necessary. The Delegated Care Coordination Entities are responsible ensuring care team meetings and conference calls are held as needed based upon the integrated whole person care plan and monitoring the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the member. Delegated Care Coordination Entities will work with the enrolled member's providers and caregivers as well as the member in the custody of the Division of Children and Family Services (DCFS) to ensure continuity of care across all services. Delegated Care Coordination Entities will document all care coordination activities with the member, caregiver, PCMP, and care team in a timely manner. We work to improve care coordinators knowledge through ongoing trainings/meetings regarding contract requirements. We have monthly care coordination subcommittee meetings with Delegated Care Coordination Entities from across the region. Care coordination providers are monitored on compliance with this requirement through existing audit and performance improvement procedures. See **CareCoordinationAuditPlan_HCI-entire document,** and **CareCoordinationAuditTool_HCI-entire document** to address this requirement.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PCMPAccountableAgreement_HCI-pages 4, 6, 18, also known as HCI's PCMP contract, specifically details the requirements of PCMP's around information sharing with other entities serving the member to prevent duplication of those activities. The PCMP is: Encouraged to adopt and track continuous performance and process improvement activities, and adoption of proven practice and process improvement tools to improve care transitions and improve coordination with specialists and other Medicaid providers, etc. PCMP's are required to track the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information in alignment with signed care compacts between the PCMP and the specialist provider. PCMPs, by execution of this Agreement, agree to participate in the ACC Program by cooperating with care coordination, case management, and medical management activities and functions implemented or conducted by HCI. PCMPs are committed to working as a partner with HCI and Beacon in providing the highest level of care to members. This commitment includes data-sharing, access to medical records when requested, including with other providers/organizations involved in the member's care, in accordance with professional standards. The PMCP shall also demonstrate cooperation with referrals, participation in performance improvement activities and initiatives, including those that align with RAE performance expectations set by the Department, willingness to give feedback and potentially participate on committees and provide clinical expertise, and use the data available to the practice to better manage	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members and their health needs. This communication expectation will promote continuity of care. **R4_narrative_CareCompacts_Q4FY21_HCI-entire document** explains HCI's established process for collecting care compacts, and outlines HCI's transition away from Care Compacts at the direction of HCPF. The goal of care compacts was to establish a mutual agreement for cooperatively providing health care services as necessary for the health care of patients between specialists, PCMP's, and Behavioral Health. The organizations in our region have mutual interest and benefit to work cooperatively in the provision of services and structures how each will work to establish and define the processes and procedures in the provision of services between the parties. **R4_CareCompactQ4_FY20-21_HCI-entire document**-was the state report submitted by HCI for Fiscal Year 2020-2021, Quarter 4, which was April, May, and June 2021. This outlines the care compacts that were new or renewed during this quarter. **SolvistaHealthandHealthTrac_CareCompact_HCI-entire document.** This agreement is an example of a of specialty care/care compact.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. *For the Capitated Behavioral Health Benefit:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* Contract Amendment 7: Exhibit B6—11.3.7.10.6, 15.1.1.5	**Documents Submitted/Location Within Documents:** 1. NoticeofPrivacyPractices_HCI- Entire document 2. NW10.17 Provider Departure and Provider Termination from Network_HCI- Entire Document 3. CO33.8_UsesandDisclosureof PHI_HCI-Entire Document 4. CO400.11MemberPrvacyRights_HCI - Entire Document 5. IT201.8 HIPAACompliance Stnd 1 SecurityMgmtProcess_HCI- Entire Document 6. IT208.9 HIPAA Compliance Stnd 8 Security Evaluation_HCI – Entire Document 7. IT216.7 HIPAA Compliance Stnd 16 Integrity_HCI - Entire Document 8. IT217.7 HIPAACompliance Stnd 17 Person or Entity Authentication_HCI- Entire Document 9. BH_Medical Record Standard_Amendment_HCI 10. BehavioralHealthProviderHandbook_HCI-Page 5, 20 *Misc. 11. HIPAAMedicaidProviderPHILetter_HCI- Entire Document 12. OM_DCWHCPF_2021_HCI- Entire Document **Description of Process:** HCI maintains policies and practices to ensure all of our members' private healthcare information is protected (See **NoticeofPrivacyPractices_HCI**). Utilizing standards, policy, and guidelines, Beacon Health Options compliance department HCI maintains all staff to follow said policies. For our members who are in transition from one provider practice to another, HCI monitors our practices' privacy policies while	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	abiding by our set standards to help with a smooth transition between entities. **NW10.17 Provider Departure and Provider Termination from Network_HCI**- Entire Document**:** To maintain network adequacy; to ensure the continuation of care; to ensure compliance with NCQA; to support the integrity of Beacon's PSAs; to maintain the accuracy of provider database, and to address issues which may cause provider dissatisfaction. **CO33.8_UsesandDisclosureof PHI_HCI**-Entire Document**:** Provides guidance to Beacon employees, contractors, and network providers on the proper guidelines for uses and disclosures of PHI. All disclosure referenced in this policy shall be made in compliance with HIPAA, HITECH Final Rule, 42 CFR part 2 and applicable state law. **CO400.11MemberPrvacyRights_HCI** - Entire Document: To ensure that Beacon employees, members and network providers have access to and are knowledgeable about Members' Rights and Responsibilities. **IT201.8 HIPAACompliance Stnd 1 SecurityMgmtProcess_HCI**- Entire Document: To publish Beacon policy governing compliance of HIPAA Security Rule requirements for Administrative Safeguards (Section 164.308) for a Security Management Process.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IT208.9 HIPAA Compliance Stnd 8 Security Evaluation_HCI: To publish Beacon policy governing compliance to HIPAA Security Rule requirements for Administrative Safeguards (Section 164.308) for a Security Evaluation. **IT216.7 HIPAA Compliance Stnd 16 Integrity_HCI** - Entire Document: To publish Beacon policy and procedures governing compliance to HIPAA Security Rule requirements for Technical Safeguards (Section 164.312) – Integrity. **IT217.7 HIPAACompliance Stnd 17 Person or Entity Authentication_HCI-** Entire Document: To publish Beacon policy and procedures governing compliance to HIPAA Security Rule requirements for Technical Safeguards (Section 164.312) – Person or Entity Authentication. The document titled **BH_Medical Record Standard_Amendment_HCI** was sent to providers with existing contracts to include medical record documentation standard. Additionally the language was added to all new provider contracts going forward (See **PCMPAccountableAgreement_HCI, Page 2**). Within **the BehavioralHealthProviderHandbook_HCI on page 5** within the contact information table, providers are given the care coordination phone number to utilize to connect with care coordination. The contact information for care coordination	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	is also included on the HCI website (https://www.healthcoloradorae.com/contact/) The importance and process of coordinating care with all treating providers is in the **BehavioralHealthProviderHandbook_HCI** on **page 20**. It delivers guidance for providers involved in the medical and/or behavioral health care and treatment of a member. All coordination, including PCMP coordination, should be documented accordingly in the member treatment record. Behavioral Health providers should contact the RAEs to get their members connected with care coordination. It also gives steps to obtain a release of information and use this to communicate with other providers. All contracted providers receive the handbook and it is posted on HCI's website under provider resources for reference (https://www.healthcoloradorae.com/providers/provider-handbook/) The document titled **HIPPAMedicaidProviderPHILetter_HCI** confirms that a covered entity may disclose PHI without the written consent of the member when it is related to administering the Department's capitated behavioral health benefit; developing a network of PCMPs to serve as medical home providers for their members; developing a contracted statewide network of behavioral health providers; onboarding and activating members; promoting the enrolled population's health and functioning, and coordinating care across disparate providers and social, educational, justice, and other community agencies to address complex member needs that span multiple	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agencies and jurisdictions. This resource also includes a link to The Office for Civil Rights (OCR) of the Department of Health and Human Services that outlines when, and under what conditions, a covered entity provider may use and disclose PHI without member authorization for the purposes of treatment, payment and health care operations. To address information sharing between the RAE and members specifically served by Departments of Human Services. The document **OM_DCWHCPF_2021_HCI**, is a memo jointly released by Division of Child Welfare in CDHS and HCPF. The memo serves was confirmation of authority for counties to share data (as listed in the memo) for child welfare populations with RAEs without the use of a Business Associate Agreement. This memo allows the RAEs to better fulfill our contractual obligation to connect foster care children with services in a timely manner. Treatment includes not only the provision of care, but also the coordination or management of healthcare and related services. Currently, the input of information into Trails and the transfer of that data into CBMS and thereby to the RAEs, is slower than is necessary and makes it more difficult for RAEs to timely serve children/youth in the foster care system. The memo was sent out to all Care Coordination Entities shortly after its release in July 2021. The document titled **NoticeofPrivacyPractices_HCI** addresses how HCI may use and disclose Protected Health Information (PHI) as well as uses of PHI that do not require authorization. The privacy notice is posted on HCI's website	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(https://www.healthcoloradorae.com/hci-notice-of-privacy-practices/).	
10. The RAE possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 7: Exhibit B6—15.2.1.1, 15.2.1.3-4	**Documents Submitted/Location Within Documents:** 1. EssetteScreenShots_HCI – entire document 2. EssetteNewMemberIntakeProcess_HCI – pages 10-15, 19-20 3. EssetteUserTraining_HCI – entire document 4. EssetteDiabetesConditionManagementProgramGuide_HCI – entire document 5. PCMPAccountableAgreement_HCI, Page 5 *Misc 6. CareCoordinationAuditPlan_HCI- entire document 7. CareCoordinationAuditTool_HCI- entire document **Description of Process:** The RAE possesses and maintains an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. Essette is HCI's Care Coordination tool. Essette collects member eligibility data, claims data, PCMP and pharmacy data to support communication and coordination among members of the provider network and health neighborhood. **EssetteScreenShots_HCI – entire document** clearly lists out where the following are documented in Essette: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Stratification level. **EssetteNewMemberIntakeProcess_HCI** is HCI's standardized care coordination intake process for all members enrolled in care coordination. The document is HCI's program guide that is used for training and reference purposes. The intake workflow ensures that Delegated Care Coordination Entities assess for external resources involved in member health, and work in conjunction with these Health Neighborhood resources for their care navigation and care management work. Specifically, this is manifested through quality communication, closing the loop, non-duplication of services, and referral management for social determinants of health resources, and transitional care management for acute and specialty care. **On page 10-15**, it clearly outlines where Delegated Care Coordination Entities chart the following: • Care coordination notes, activities, and member needs. **On page 19-20**, it clearly outlines where Delegated Care Coordination Entities chart the following: • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	EssetteUserTraining_HCI – entire document – is a basic user guide given to new Delegated Care Coordination Entities. This is the training document used in Essette 101 trainings and goes over all functions of Essette. **EssetteDiabetesConditionManagementProgramGuide_HCI – entire document –** is a user guide for HCI's regional Diabetes Condition Management programming. This training was provided to Delegated Care Coordination Entities on 8/25/2021 and 9/1/2021 via the monthly care coordination meeting and monthly Essette Steering Committee meeting, and attached to meeting minutes for all participants. The document titled **PCMPAccountableAgreement_HCI, Page 5** outlines the auditing procedures detailed in the **CareCoordinationAuditPlan_HCI** (entire document), utilizing the **CareCoordinationAuditTool_HCI** (entire document) which reflects the contractually identified elements of a care plan and care coordination activities. The treatment record standards and guidelines are further detailed in the document titled **BehavioralHealthProviderHandbook_HCI, page 84-86**.	

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 7: Exhibit B6—7.3.7.1–2	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_HCI-entire policy *Misc. **Description of Process:** Health Colorado Inc. (HCI) adheres to Beacon Health Options (Beacon) Member Rights and Responsibilities Policy, which guides our position on protecting member rights. The Members Rights and Responsibilities policy meets all state and federal regulations and contract requirements. Please see: 304L_MemberRandRPolicy_HCI, entire policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 7: Exhibit B6—17.10.7.2	**Document Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_HCI-page 10 *Misc. 2. Employee AttestationofMemberRights_HCI, entire document 3. 310LNonDiscriminationPolicy_HCI, entire document 4. Non-Discrimination Notice_HCI, entire document 5. Provider Contract_HCI, pages 8, 28 6. BehavioralHealthProviderHandbook_HCI, page 14 *Misc. 7. PhysicalHealthProviderHandbook_HCI, Page 13 *Misc. 8. Provider Roundtable Powerpoint_HCI, Slide 17 9. Feedback Database_HCI-page 2 10. ChartAuditTool_HCI, Line 14 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: HCI complies with all applicable federal and state laws that pertain to member rights and ensures that all of their employees and contracted providers observe and protect these rights. HCI follows Beacon's two (2) policies and procedures, which outlines member rights. These two (2) policies are: 1) Member Rights and Responsibilities (304L_MemberRandRPolicy_HCI); and 2) Non-Discrimination (310LNonDiscriminationPolicy_HCI). HCI requests that both Beacon and HCI staff read and sign a copy of the Member Rights and Responsibility Policy (see page 10 of 304L_Member RandRPolicy_HCI). Beacon and HCI staff must attest that they have read the Members Rights and Responsibilities policy and that they are expected to treat members in a manner that respects their rights. For examples of signed attestations, see Employee AttestationofMemberRights_HCI. HCI also adheres to the non-discrimination policy (310LNonDiscriminationPolicy_HCI) which outlines that we will not discriminate against members based on race, color, ethnic or national origin, ancestry, religion, creed, sex, gender, sexual orientation, gender identity and expression, age, disability, handicap, health status (including Acquired Immune Deficiency Syndrome (AIDS) or an AIDS-related condition, the need for health care services, or political beliefs in context of receiving care and services from HCI. See	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Non-Discrimination Notice_HCI, entire document. HCI's non-discrimination notice is on their website. See: https://www.healthcoloradorae.com/non-discrimination-notice/. See also Non-Discrimination Notice_HCI, entire document. HCI's contracted providers sign a contract stating that members with disabilities will have the same standard of care as other members and will not be discriminated against (page 8) and that providers will agree to take into account member's rights (page 28). HCI outlines member rights in the provider handbook (see page 17). HCI also educates contracted providers annually about member rights in a provider roundtable forum. See the following evidence: 1) ProviderContract_HCI, pages 8 and 28; 2) BehavioralHealthProviderHandbook_HCI, page 14; 3) PhysicalHealthProviderHandbook_HCI, Page 13; and 4) Provider Roundtable PowerPoint_HCI, slide 17. If a Member believes that their rights have been violated, they or their designated client representative (DCR) can make a complaint at any time by phone, letter, in person, or by sending an email. HCI delegates the oversight of member complaints to Beacon who monitors, documents, and categorizes all member complaints. HCI has a specific category related to the violation of member rights. Please see Feedback Database_HCI-page 2.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI also has information regarding rights/responsibilities, civil rights, the Americans with Disability Act on our website. See: https://www.healthcoloradorae.com/members/rights-responsibilities/. HCI's Quality Management department completes chart audits for our contracted providers. The Quality Management department reviews member charts to ascertain if providers have reviewed rights and responsibilities with members. This information is documented in the chart audit tool. See ChartAuditTool_HCI, entire document, line #14. HCI ensures that providers offer members information about their accommodations for disabilities. The provider directory has a field entitled ADA Compliant, which is answered by a "yes" or "no" by the provider. Members can also call HCI's call center to have our staff find out the specific accommodations that the providers have for our members with disabilities.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for their dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 7: Exhibit B6—7.3.7.2.1–6	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_HCI, pages 1-3, sections iii., iv, vii, x, xiii, xxi, xxii, xxxiii*Misc. 2. 307L_MemberInfoReqPolicy_HCI, page 2, C*Misc. **Description of Process:** HCI has policies in place to make certain that each member is guaranteed their rights in accordance with federal guidelines. 304L_MemberRandRPolicy_HCI outlines the following; • Members will receive information in accordance with information requirements (42 CFR 438.10) (Page 1, section iii). • Members will be treated with respect and with due consideration for their dignity and privacy (page 1, section IV). • Members will receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand (page 2, section xxii). • Members can participate in decisions regarding their health care, including the right to refuse treatment (page 1, section vii).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Members can be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (page 2, section xxii). • Members can request and receive a copy of their medical records and request that they be amended or corrected (page 3, xxxi). • Members will be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210) (page 2, section xiii). See 304L_MemberRandRPolicy_HCI, pages 1-3. Additionally, HCI follows the Member Information Requirements Policy and Procedures to ensure that Members are given information in accordance with the requirements stated in 42 CFR438.10. See 307L_MemberInfoReqPolicy_HCI, page 2, C.	
4. The RAE ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the RAE, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 7: Exhibit B6—7.3.7.2.7	**Documents Submitted/Location Within Documents:** 1. RightsandResponsibilities_HCI, entire document 2. RightsandResponsibilities_Spanish_HCI, entire document 3. RightsandResponsibilitiesPoster_ HCI, entire document 4. RightsandResponsibilitiesPosterSpanish_HCI, entire document 5. EvidenceofPostersHung_HCI, entire document 6. Getting Started PPT_HCI, slides 16-18 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	7. Complaint Guide_HCI, pages 1-2 8. 304L_MemberRandRPolicy_HCI-page 2, x, *Misc. 9. BehavioralHealthProviderHandbook_HCI, page 14 *Misc. 10. PhysicalHealthProviderHandbook_HCI, Page 13*Misc. 11. Provider Roundtable Powerpoint_HCI, slide 17 **Description of Process:** HCI has a complaint process in place to ensure that members are free to exercise their rights. These processes safeguard members who choose to use their rights to not be adversely treated by HCI, network providers, or Health First Colorado (Colorado's Medicaid Program). HCI delegates the complaint process to Beacon. Beacon's Member Engagement team is responsible to educate members and providers about member rights and that members cannot be retaliated against for using their rights. The member engagement team also helps resolve any violation of a member's right and investigates any perceived and/or real retaliation against the member for using their rights. HCI educates members about their rights through several platforms: • The first platform is through our website. A rights and responsibilities PDF document in	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	both Spanish and English outlines that members are able to use their rights and file a complaint without fear of being treated poorly (#9). See the website: https://s18637.pcdn.co/wp-content/uploads/sites/26/Member-Rights-and-Responsibilities.pdf. This document is also included in the evidence section. See RightsandResponsibilities_HCI, entire document and RightsandResponsibilities_Spanish_HCI, entire document. • The second platform is hanging rights and responsibilities posters at provider sites in prominent locations in both English and Spanish. Please see RightsandResponsibilitiesPoster_HCI, RightsandResponsibilitiesPosterSpanish_HCI, and EvidenceofPostersHung_HCI. • The third platform is through a "getting started" webinar we offer members. HCI educates members on how they can exercise their rights without retaliation. See Getting Started PPT_HCI, slides 16-18. • The fourth (4th) platform is the complaint guide that states that members can use their rights to file a complaint. See: https://s18637.pcdn.co/wp-content/uploads/sites/26/Complaint-	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Guide.pdf. The guide states that members will not be treated differently for making a complaint (i.e., exercising their rights). This is available in both English and Spanish. See Complaint Guide_HCI, pages 1-2. Health Colorado follows Beacon's Member Rights and Responsibilities Policy to ensure that each member is free to exercise their rights and that they will not be treated adversely by the RAE, network providers, or the state Medicaid agency (Healthcare, Policy, and Financing). See 304L_MemberRandRPolicy_HCI, page 2, X. HCI educates providers through two (2) avenues about members' ability to exercise their rights. The first (1st) avenue is in the provider handbook. The handbook describes how members can file a complaint and that members will not lose their Health First Colorado benefits, be treated differently, or be restricted access to services for filing a complaint. See BehavioralHealthProviderHandbook_HCI, page 14 and PhysicalHealthProviderHandbook_HCI, Page 13. The second (2nd) avenue is through an education forum called provider roundtables. Providers are taught that members can file a complaint when they believe their rights have been violated and that they cannot be treated differently for using those rights. See Provider Roundtable Powerpoint_HCI, slide 17.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract Amendment 7: Exhibit B—11.3.7.10.6, 15.1.1.5	**Documents Submitted/Location Within Documents:** 1. Policy 33.8 UsesandDisclosureofPHI_HCI-page 1 2. 304L_MemberRandRPolicy_HCI-pages 8-9m section iv *Misc. 3. PCMPAccountableAgreement_HCI, page 10 *Misc. 4. ProviderContract_HCI, pages 13, 22 5. PrivacyNotice_HCI, entire document 6. ChartAuditTool_HCI, Line 15 *Misc. **Description of Process:** HCI uses and discloses members' identifiable health information found in medical records and other health and enrollment information that identifies a unique member in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. HCI's staff comply with Beacon's Policy 33.8 UsesandDisclosureofPHI_HCI. On page one (1), the policy states that staff may use and disclose PHI only as permitted or required by federal privacy law and relevant state law. The policy states that staff will make reasonable efforts to limit the use and disclose	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	only the "minimum necessary" information needed to accomplish the intended purpose. HCI staff adheres to 304L_MemberRandRPolicy_HCI, which states on page 8 that the confidentiality policies and procedures must conform to all federal and state confidentiality laws and regulations. In this same policy, it states that Members have the right to request, obtain a copy of their PHI, and ask HCI to amend or correct their PHI. See 304L_MemberRandRPolicy_HCI, pages 8-9, section iv HCI posts our privacy notice on our website. See https://s18637.pcdn.co/wp-content/uploads/sites/26/HCI-Notice-of-Privacy-Practices.pdf. This privacy notice describes how medical information about a member may be used and disclosed and how a member can get access to this information. The privacy notice identifies HCI's privacy officer as a person to contact if a member believes that their privacy rights have been violated. See PrivacyNotice_HCI, entire document. HCI requires accountable Primary Care Medical Providers (PCMPs) to sign an agreement stating that they are responsible for compliance with all applicable provisions of state and federal law, which includes a member's medical record. On page ten (10), the	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	agreement states that the PCMP is and remains responsible for compliance with all applicable provisions of state and federal law, which includes a Member's medical record. See PCMPAccountableAgreement_HCI, page 10. HCI also requests behavioral health contracted providers to sign a contract stating that they will comply with all state and federal laws relating to members' confidentiality rights. See ProviderContract_HCI, pages 13, 22. HCI's Quality Department completes chart audits for our contracted providers. The Quality Department reviews member charts to ascertain if providers have reviewed the notice of privacy with members. This information is documented in the chart audit tool. See ChartAuditTool_HCI, line #15.	
6. The RAE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience.	**Documents Submitted/Location Within Documents:** 1. 269L_AdvanceDirectivesPolicy_HCI, entire policy 2. Advance Directives Training Flyer_HCI, entire document 3. Advance Directives PPT_HCI, entire document 4. BehavioralHealthProviderHandbook_HCI, Page 16 *Misc. 5. PhysicalHealthProviderHandbook_HCI, Pages 15-16 *Misc. 6. ChartAuditTool_HCI, entire document *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives.	**Description of Process:** HCI maintains a policy and procedure concerning advance directives for adult members who may be receiving treatment through one of HCI's providers. This policy is located on our website and members can request this information to be printed and sent to them free of charge. See https://www.healthcoloradorae.com/members/advance-directives-living-will/. HCI has links for the advance directive policy, the Colorado Medical Advance Directives, Colorado's Psychiatric Advance Directives, Five Wishes, Achieve Solutions articles, and information on how members, providers, and community members may participate in a training on advance directives the last Thursday of each month. The advance directive policy contains the following information: • Notice that members have the right to request and obtain information about advance directives at least once per year (page 4). • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience (page 2) – The difference between institution-wide conscientious objections and those raised by individual physicians (page 2).	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. – To educate of staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *The RAE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 7: Exhibit B6—7.3.11.2, 7.3.11.3.3	– Identification of the State legal authority permitting such objection (Page 2). – Description of the range of medical conditions or procedures affected by the conscientious objection (page 2). • Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information (page 3) – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated (page 3). – To document in a prominent part of the member's medical record whether the member has executed an advance directive (page 3). – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive (page 4).	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	– To ensure compliance with State laws regarding advance directives (page 1). – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment (page 4). – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law (page 1). – To educate of staff concerning its policies and procedures on advance directives (page 4). – The components for community education regarding advance directives that include the following information are found on page 4: ▪ What constitutes an advance directive? ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. Please see 269L_AdvanceDirectivesPolicy_HCI, entire policy.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI provides a monthly Advance Directive training for all members, families, care coordinators and providers on the last Thursday of each month. HCI's member engagement specialist is an advance directives trainer for our members. HCI promotes the monthly advance directives training through the following platforms: 1) social media sites; 2) care coordination meetings; 3) Department of Human Services (DHS) quarterly meetings; 4) "getting started" webinars; 5) member advocate meetings; 6) practice transformation coaches, 6) provider roundtables and 7) provider newsletters. Please see Advance Directives Training flyer_HCI and Advance Directives PPT_HCI. HCI's providers are also made aware of advance directives through the provider handbook. Please see BehavioralHealthProviderHandbook_HCI, Page 16, PhysicalHealthProviderHandbook_HCI, Pages 15-16. HCI's Quality Department completes chart audits for our contracted providers. The Quality Department reviews member charts to ascertain if providers have asked members eighteen (18) and older about advance directives. This information is documented in the chart audit tool. See ChartAuditTool_HCI, entire document, line #72.	

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 7: Exhibit B6—7.2.5, 7.3.6.1	**Documents Submitted/Location Within Documents:** 1. 307L_MemberInfoReqPolicy_HCI, Page 1, 2 and 3 *Misc. 2. MEACSummary_HCI, pages 1-2 3. CoverSheet_HCI, entire document 4. IT302.5_508ComplianceofExternalWebSitesPolicy_HCI-entire policy 5. WebsiteComplianceCheck_HCI, entire document **Description of Process:** HCI provides all required member information in a manner and format that may be easily understood and is readily accessible by members and complies with Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's web content accessibility guidelines. HCI observes the procedures found in 307L_MemberInfoReqPolicy_HCI to ensure that the information we provide members is in a format that is easily understood. Some of the highlights from this policy include: • That we will provide member informational materials and instructional materials in a manner and format that are readily accessible, accurate, easily understood, and provide information as required by State, Federal and contractual guidelines (page 1).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Our procedures to ensure that member materials are written at a sixth (6th) grade reading level so that they are clear, concise and understandable to the representative population. HCI runs all member material through the Flesch-Kinkaid readability program, which ascertains the minimum education level required to understand materials (307L_MemberInfoReqPolicy_HCI page 3). • Our commitment to have our materials member-tested and make necessary changes, which are recommended by our members (307L_MemberInfoReqPolicy_HCI page 3). HCI records the member materials that are reviewed with members for large-scale member communication at our Member Experience Advisory Council (MEAC), our member services subcommittee, or our focus groups. Members are asked to test the material and identify concerns with content and/or layout. HCI edits the material based on the member feedback. For example, our "getting started" guide was reviewed with members who gave several tips to enhance the readability and layout of the document. For evidence of reviewed member material, see MEACSummary_HCI, pages 1-2. HCI includes a cover sheet with all member mailings, including any large-scale member communication. The cover sheet is used to protect members' privacy and provides members with information on how to request information in	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	alternative formats, oral interpretation, or written translation for free. The cover sheet is written in large font, has the toll free and TTY/TDD number listed, and is used for any mailings and when a member requests a copy of a member handbook and/or a provider directory. HCI's electronic information (website) complies with 508 guidelines and W3C's Web Content Accessibility Guidelines. HCI has delegated our website management to Beacon. Beacon uses the IT302.5_508ComplianceofExternalWebSitesPolicy_HCI to ensure compliance with our website being readily accessible. The policy addresses our website being readily accessible as found on the following pages: • External websites must adhere and meet 508 compliance standards (page 1). • Under Section 508, agencies must give disabled employees and members of the public access to information that is comparable to the access available to others (page 2). • Information about World Wide Web Consortium (W3C) that leads the website to its full potential is addressed (page 2). • The purpose of the policy is to publish procedures for the development of external websites to ensure that 508 compliance is maintained (page 2). This includes priority checklist items. Priority one (1) items must be addressed and are required to make a site accessible – page 2. Priority two (2) checklist items, which	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	should be addressed to make the site accessible, but these items, are not required – page 4. Priority three (3) checklist items, which could be addressed to improve the accessibility of a site – page 6. Beacon's website team conducts periodic reviews for 508 compatibility on our website. Any detected non-508 compliance is brought to the attention of HCI's member engagement specialist for remediation. Beacon's website team corrects the identified accessibility issues and the member engagement team resolves issues with broken website links or accessing PDF documents. For evidence of this period report, see WebsiteComplianceCheck_HCI, entire document.	
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 7: Exhibit B6—7.38.1	**Documents Submitted/Location Within Documents:** 1. Texting Scripts_HCI, entire report *Misc. 2. Welltok Monthly Report_HCI, entire document 3. Getting Started PPT_HCI, Pages 9-15 *Misc. 4. DHS PPT_HCI, Page 8 5. Care Coordination Meeting Minutes_HCI, Page 3 6. Provider Newsletter_HCI, Page 3-4 *Misc. 7. HCPFWelcomeLtr_HCI, entire document *Misc. **Description of Process:** HCI has several mechanisms in place to help members understand the requirements and benefits of the plan. The mechanisms are described below:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	1) HCI has a texting campaign called Welltok designed to help members understand the requirements and benefits of the plan. Texting campaigns to help member learn about their benefits include but are not limited to: Welcome message, member handbook information, website link information, well child visits reminders, the nurse advice line number, member rights, advance directives, vaccinations, behavioral health, crisis services, and how to get an insurance card. Please see Texting Scripts_HCI and Welltok Monthly Report_HCI. 2) HCI hosts a "getting started" ZOOM webinar on the first Thursday of each month to educate members about their benefits and requirements of their plan. HCI promotes this webinar through social media, practice transformation coaches, provider newsletters, care coordinator meetings, and DHS eligibility technicians meetings. See Getting Started PPT_HCI, slides 9-15, DHS PPT_HCI, page 8; Care Coordination Meeting Minutes_HCI, Page 3; and Provider Newsletter_HCI, Pages 3-4. HCI has a new member information packet on their website. See https://www.healthcoloradorae.com/members/new-member-welcome-packet/. The packet has relevant benefit information for our members including but not limited to: the PEAK app, transportation, member handbook, and how to find a provider. HCI worked with HCPF to include this new member welcome pack link in the welcome letter that HCPF sends to new members. See HCPFWelcomeLtr_HCI, entire document.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit B6—3.6, 7.3.4	**Documents Submitted/Location Within Documents:** 1. Managed Care Terms_HCI, entire document 2. HCPF Branding Guide_HCI, page 10 **Description of Process:** HCI uses managed care definitions provided by Healthcare, Policy and Financing (HCPF) to maintain consistency in the information that is provided to our members. HCI developed a Managed Care Terms Explained resource for our members after researching managed care definitions provided by HCPF. HCI used the Health First Colorado's (Colorado's Medicaid Program) member handbook and HCPF's website to create this resource. The managed care terms explained document can be found on the resource tab on our website at: https://www.healthcoloradorae.com/resources/#mct. See Managed Care Terms_HCI, entire document. HCI does not have an independent member handbook, however, uses Health First Colorado's member handbook developed by HCPF. The member handbook is displayed on the main page of our website. HCI uses HCPF's branding guide to model our member materials and notices. HCI includes Health First Colorado's logo on our entire member facing material including our website. See main page of website for evidence of the member handbook and Health First Colorado logo. See https://www.healthcoloradorae.com and HCPF Branding Guide_HCI, page 10.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested.	**Documents Submitted/Location Within Documents:** 1. NonEnglishSpeakingSummary_HCI, entire document 2. 307L_MemberInfoReqPolicy_HCI, entire policy *Misc. 3. Cover Sheet_HCI, entire document 4. MeetingMinutes_HCI, page 2 **Description of Process:** HCI makes written information available for members, which are critical to obtain services available in prevalent non-English languages in our nineteen (19) county region area. HCI informs members that they can request this information in alternative formats upon their request at no cost to them. HCI identified Spanish as the most prevalent non-English language in our region. According to the 2019 Data USA report, there are 16.7% Non-English Speakers in Colorado with the most common non-English language being Spanish. 11.4 % of Colorado's overall population are native Spanish speakers, followed by Chinese at .44% and German at .42%. HCI understands that the most common resource for members to understand their services is the member handbook. HCI has the Spanish version of the member handbook on the main page of our website. To see a copy of the handbook, click: https://www.healthcoloradorae.com. For evidence of Spanish as the most prevalent non-English language, see NonEnglishSpeakingSummary_HCI, entire document.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(d)(3) and (d)(6) Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3	HCI has nineteen (19) languages accessible through Google Translate available on our website. In the lower right hand corner of the website, you can click on the flag to access other languages. HCI's website notifies members that they can ask for information in large print, Braille other formats or languages, American Sign Language, or to be read aloud. These services are free. See the main page of our website. See https://www.healthcoloradorae.com for evidence of google translate and information that members can request for alternative languages for free. HCI follows the procedures found in 307L_MemberInfoReqPolicy_HCI to ensure that the information we provide members is in a format that is easily understood. This policy states that member information: • Will use easily understood language and formats (page 3). • Will use a font size no smaller than 12-point and no smaller than 18-font for large print (page 3). • Will include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats (page 3). • Be available in alternative formats and through provision of auxiliary aids and service that take into	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	consideration the special needs of members with disabilities or limited English proficiency (page 3). • Will be member-tested and make necessary changes, which are recommended by our members (page 3). HCI presented the complaint resolution letter to members in the member services subcommittee to "member-test" the format and language. HCI members provided excellent feedback, which improved our processes for sending out grievance, appeal, provider termination and denial notices. HCI worked with the members to develop a cover sheet that would be attached to members' notices. The cover sheet protects members' privacy and provides members with information on how to request information in alternative formats, oral interpretation or written translation for free. The cover sheet is written in large font and has the toll free and TTY/TDD number listed. The cover sheet is used if a member requests a copy of a member handbook and a provider directory. See MeetingMinutes_HCI, page 3 and Cover Sheet_HCI, entire document.	

Findings:

The *Member Information Requirements* policy described procedures for ensuring that member informational materials contain taglines that are consistent with the member information requirements. However, some critical member materials did not include all required components of a tagline.

- The cover sheet, welcome letter, and provider directory had taglines but did not have the entire tagline translated in Spanish.
- The newly pregnant member welcome letter, *HCI Brochure*, *Getting Started Flyer*, *Getting Started Pregnancy Guide*, *EPSDT Tip Sheet*, welcome letter, and *Care Coordination Fact Sheet* did not have a tagline in English and Spanish.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: HCI must revise critical member materials to include all required components of a tagline.		
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	**Documents Submitted/Location Within Documents:** 1. IT302.5_508ComplianceofExternalWebSitesPolicy_HCI, entire document 2. WebsiteComplianceCheck_HCI, entire document 3. Evidence of Member Handbook Request_HCI, Page 2 **Description of Process:** HCI makes information available to members electronically through our website, https://www.healthcoloradorae.com. HCI has delegated our website management to Beacon Health Options. Beacon uses the IT302.3_508 Compliance of External Websites Policy to guide our process of ensuring compliance with this requirement. The policy outlines the procedures for website compliance checks to ensure that we are meeting readily accessible standards described in 508 guidelines, Section 504 of the Rehabilitation Act, and W3Cs web content accessibility guidelines. The policy states that documents must use the clearest and simplest language appropriate for the site's content on page 4. HCI runs all member approved PDF documents, which meet content and language requirements through a 508 accessibility scan before uploading the content to the website. All member-approved material meets the content and language requirements. Please see IT302.3_508 Compliance of External Websites Policy, entire document and WebsiteComplianceCheck_HCI for evidence of this requirement.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI identified the two (2) crucial elements for members to obtain services are the member handbook and the provider directory. These two (2) resources can be found in a prominent location on the main page of the website. See: https://www.healthcoloradorae.com. Members can find the member handbook on the middle of the main page and the provider directory embedded in the "find a provider" tab located on the top purple bar or through the member icon. These resources can be electronically retained and printed for member use. HCI routinely tests this function when a member requests a copy of the member handbook or provider directory. HCI informs members that they can request information from the website to be sent to them in paper form within five (5) days for free. See: https://www.healthcoloradorae.com/members/. When a HCI's call center associate receives a member request for a handbook or provider directory, the call center associate emails the member's contact information to the member engagement department to send the requested item. See: Evidence of Member Handbook Request_HCI, Page 2. HCI provides a link to Health First Colorado's website on the front page of our website. This ensures that members have standardized information such as member rights and member handbooks. See: https://www.healthcoloradorae.com.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: During the review, staff members reported that HCI received minimal ad hoc printing requests. Although HCI submitted an email as evidence to show how HCI communicates internally to fulfill such requests, HCI could not provide supporting documents to demonstrate how HCI monitors the five-day requirements for such requests. HCI reported an opportunity to begin using an MS Excel tracking mechanism to document timely mailing of ad hoc printing requests. HCI's general member webpage and provider directory webpage included a statement that materials can be printed but did not include "within five business days." HSAG recommends that, as best practice, the full statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page).		
Required Actions: HCI must develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost.		
6. The RAE makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(i)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. HCPF Preferred Drug List_HCI, entire document **Description of Process:** HCI makes Health First Colorado's medication formulary available to members electronically on our website, which is in a machine-readable format. If a member requests this information to be sent to them in a paper form, HCI would send the formulary information at no charge to the member within five (5) days. See HCPF Preferred Drug List_HCI, entire document. HCI has HCPF's medication formulary link on our website under resources/prescriptions. The preferred drug list has information on which medications are covered – both generic and name brand as well as which tier each medication is on.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	See https://www.healthcoloradorae.com/resources/#prescription.	
7. The RAE makes interpretation services (for all non-English languages) and use of auxiliary aids such as TTY/TDD and American Sign Language available free of charge, notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and informs about how to access those services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 7: Exhibit B6—7.2.6.2–4	**Documents Submitted/Location Within Documents:** 1. Cover Sheet_HCI, entire document 2. Getting Started Flyer_HCI, entire document *Misc. 3. BehavioralHealthProviderHandbook_HCI, page 45 *Misc. 4. PhysicalHealthProviderHandbook_HCI, page 12*Misc. 5. ChartAuditTool_HCI, entire document *Misc. 6. Access2SignLanguageAgreement_HCI, entire document 7. 311L_Responding to Members with LEP_HCI, entire document 8. 307L_MemberInfoReqPolicy_HCI, Page 3 *Misc. **Description of Process:** HCI makes interpretation services and translation services available for all non-English speaking members, members with Limited English Proficiency (LEP), and Deaf/hard of hearing members. These services are available free of charge to members. These services could involve the use of oral interpretation for any language including American Sign Language (ASL) and auxiliary aids such as TTY/TDD. Written translation is available in prevalent languages (Spanish) and members are made aware of how to access these services. HCI informs members how to access these services through a variety of mediums.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	1) HCI's website. HCI includes information about how to ask for interpretation services on the main page of our website. See https://healthcoloradorae.com. 2) HCI's cover sheet. HCI's cover sheet is attached to all written correspondence sent to members. The cover sheet provides members with information on how to request information in alternative formats, request oral interpretation or written translation at no charge to the member. The cover sheet is written in large font and has the toll free and TTY/TDD numbers listed. 3) Member invitations. HCI adds language on how to access reasonable accommodations on member invitations such as our "getting started" flyer. HCI has contracts with agencies to provide sign language and/or interpretation services when these services are needed. 4) Provider Knowledge. HCI informs providers of their responsibility to offer interpreter services for members in the provider handbook page 79 and physical health provider handbook page 12. The handbook explains that providers can contact HCI to receive help with setting these services up. Please see: Cover Sheet_HCI, entire document; Getting Started Flyer_HCI, entire document; Access2SignLanguageAgreement_HCI, entire document and BehavioralHealthProviderHandbook_HCI, page 45 and PhysicalHealthProviderHandbook_HCI, Page 12.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's Quality Department completes chart audits for our contracted providers. The Quality Department completes reviews member charts to ascertain if providers have indicated a need for interpretation services. This information is documented in the chart audit tool. See ChartAuditTool_HCI, entire document, line #63. HCI educates the call center staff to assist members who are non-English speaking, LEP, or Deaf/hard of hearing who call HCI to request assistance. Call center staff are trained on how to access Voiance®, our language service company to connect members with an interpreter in real time. Voiance® is a leading provider of language interpreting and can serve members in over 150 languages. The language service is available to our members twenty-four (24) hours a day, seven (7) days a week (24/7) and is free of charge to our members. HCI follows the policy, 311L_Responding to Members with LEP_HCI to direct our practices with members who are non-English speakers, LEP, or Deaf/hard of hearing. The policy describes the procedures for handling calls and responding to requests from providers and members for interpretation and or translation services. Attached to the policy is a guide, "Working with Interpreters," which instructs staff members on how to use an interpreter. Please see 311L_Responding to Members with LEP_HCI, entire document. HCI follows the policy, 307L_MemberInfoReqPolicy_HCI. The policy outlines on page 3 that member materials are	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	orally translated into other languages when requested by the member at no charge to the member. The policy states that member materials are available in alternative formats for members who have communication disabilities free of charge. Alternative formats include large type, audio tape, TTY/TDY, and ASL.	
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 7: Exhibit B6—7.2.6.1, 7.2.6.5	**Documents Submitted/Location Within Documents:** 1. 311L_Responding to Members with LEP_HCI, entire document 2. Resource Sheet_HCI, entire document 3. VoianceUse_HCI, entire document 4. BehavioralHealthProviderHandbook_HCI, Page 45 *Misc. 5. PhysicalHealthProviderHandbook_HCI, Page 12 *Misc. **Description of Process:** HCI ensures that language assistance is provided at all points of contact for a Member, in a timely manner, and during all hours of operation. HCI has a 24/7 toll-free customer service number which provides easy access to interpreter or bi-lingual services through Voiance® which has interpreters in over 150 languages. There are several points of contact with our members. • Members calling to access services and/or asking for help to find a provider • Members engaging/attending provider appointments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Members attending our meetings such as Member Experience Advisory Council (MEAC) or Performance Improvement Advisory Committee (PIAC) • Members needing assistance to make a complaint, file an appeal, or needing help with a state fair hearing HCI uses the procedures found in our policy 311L_ Responding to Members with LEP_HCI. According to this policy, • Language interpretation services are available 24/7, 365 days a year (page 1). • The process for how to use the language line is outlined (page 2). • How to use the relay line for members who are Deaf/hard of hearing is explained (pages 2-3). • The steps we take when a provider and or PIAC/MEAC committees needs an interpreter for a session or meeting (page 3). • The process of using interpretation services if they are needed beyond the initial phone call, such as a request of oral interpretation of written materials (page 3). • An educational guide, “working with interpreters” is available for all staff working with members to use (pages 5-6) Please see 311L_Responding to Members with LEP_HCI, entire document, pages 1-3 5-6. HCI’s call center staff use the language line number listed on a resource sheet if a	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member needs interpretation services. See Resource Sheet_HCI. HCI is able to capture the number of calls, which required interpretation services through Voiance. The document show that of the 152 calls needing interpretation services, 96.1% of the calls were for Spanish speaking members. See VoianceUse_HCI, entire document. HCI's call center staff are trained on how to use the referral connect system to identify a bilingual provider for clinical services. HCI uses this process when members request a non-English provider or provider who uses ASL. If we cannot find an in-network provider who is bilingual or signs, we would process a Single Case Agreement (SCA) when an appropriate provider is found. If an appropriate provider cannot be identified, HCI's member engagement specialist will set up interpretation services to assist a provider with their service interactions with the member. If interpretation services are needed for an administrative reason, (complaints or appeals) the member engagement specialist will connect with an interpreter and set up a conference call to discuss the complaint or appeal with the member. Providers can contact HCI's call center if they need language interpretation for a member. HCI's member engagement specialist will assist the provider in setting up these services. HCI is contracted with the Asian Pacific Development Center. Asian Pacific Development Center has	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	interpreters available for face-to-face, telephonic, or Skype interpretation in approximately seventy (70) languages. You can visit their website at https://www.apdc.org/. Providers can find out about this resource in the provider handbook on page 17. See BehavioralHealthProviderHandbook_HCI, Page 45, PhysicalHealthProviderHandbook_HCI, Page 12.	
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* Contract Amendment 7: Exhibit B6—7.3.8.1	*Instructions: Unless the RAE has its own handbook or supplement, score this Not Applicable.* HCI exclusively uses Health First Colorado's member handbook.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 7: Exhibit B6—7.3.8.2	*Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable.* HCI exclusively uses Health First Colorado's member handbook.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 7: Exhibit B6—7.3.8.1	*Instructions: If the RAE does not produce a handbook or supplement, score Not Applicable. If the RAE produces its own handbook or supplemental handbook—(a) review for accuracy of any applicable elements and (b) must reference the Department's handbook.* HCI exclusively uses Health First Colorado's member handbook.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received their primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit B6—7.3.10.1	**Documents Submitted/Location Within Documents:** 1. 304L_MemberRandRPolicy_HCI-page 7 *Misc. 2. CUR140.8 Continued Access when Network Providers Discontinue Participation in Beacon's Network, entire document 3. ProviderTerm Template_HCI, entire document **Description of Process:** Beacon makes a good faith effort to give written notice to our members regarding the termination of a contracted provider they have been receiving primary care from or were seeing on a regular basis. Beacon sends letters to members impacted by a provider's termination within fifteen (15) days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later. Beacon has this member right documented in our	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member Rights & Responsibility Policy. Please see 304L_MemberRandRPolicy. Beacon's provider disenrollment process encompasses several departments before a member is sent notification of provider termination. Beacon follows CUR140.8 Continued Access when Network Providers Discontinue Participation in Beacon's Network. Beacon sends a letter to impacted members to inform them of the change in their providers' network status and offers to assist members find a new provider. See Provider Term Letter_HCI.	
13. The RAE shall develop and maintain a customized and comprehensive website that includes: • The RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory. • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information.	**Documents Submitted/Location Within Documents:** 1. WebsiteUpdateRequests_HCI, entire document 2. JobAidforWebsiteUpdates_HCI, entire document **Description of Process:** HCI has delegated the maintenance of their website to Beacon. Beacon developed a website for HCI when the contract commenced in 2018 (see www.healthcoloradorae.com). Beacon maintains and updates the website as frequently as needed. See WebsiteUpdateRequests_HCI, entire document.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 7: Exhibit B6—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	HCI's website is customized and comprehensive and includes all of the required information in the following sections: HCI's home page has the following information: • HCI's contact information • Health First Colorado's Nurse Advice Line's phone number and link • Colorado Crisis Services information • Link to Health First Colorado's website • Link to the Member handbook in both Spanish and English • Find a Provider HCI's Member tab has the following information: • Access to Care Standards • Complaints & Appeals, • Find a Provider • Rights & Responsibilities. HCI's About tab outlines: • The general functions of the RAE HCI's News tab has: • Trainings for members listed under Calendar & Events. Trainings include "Getting Started Webinar and Advance Directives Trainings. Other ad hoc trainings are also located in this section.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's member engagement team follows a job aid to request website updates for member topics. The member engagement team tracks the requested changes. See JobAidforWebsiteUpdates_HCI, entire document and WebsiteUpdateRequests_HCI, entire document.	
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly if the RAE does not have a mobile-enabled, electronic directory; or quarterly if the*	**Documents Submitted/Location Within Documents:** 1. Provider Directory_HCI, entire document **Description of Process:** HCI makes available for members a provider directory on our website in a PDF format. The directory contains information about HCI's contracted behavioral and physical providers. HCI also has mobile-enabled electronic resource available on our website under the "find a provider" section. See https://www.healthcoloradorae.com. HCI delegates provider management to Beacon. The Provider Relations (PR) team has an automated process to update this directory on a monthly basis. Our providers are responsible to update any pertinent information relating to their practice through provider connect. Provider updates could include their availability to see members, change in specialty, updated address and/or phone number. If a provider states they are not currently accepting new members, the PR team requests for a temporary hold to be placed on the provider file so their name does not come up in the directory.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE has a mobile-enabled, electronic provider directory; and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information. *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit B6—7.3.9.1.6-7	Beacon's PR team oversees the process to update the provider directory no later than thirty (30) days from receipt of updated provider information, which is captured in the updated provider directory. The provider directory contains: • Provider name and group affiliation • Provider address and telephone number • Provider URL website address • Provider specialty • Provider linguistic capabilities including ASL • Provider cultural competency training • Whether providers are accepting new patients (this can change frequently and providers are responsible to update their availability) • Accommodations for people with disabilities (ADA) Please see Provider Directory_HCI, entire document. HCI's provider directory can be viewed and/or printed by a member if they have access to a printer. A member can call and ask to have a printed copy of the directory to be mailed to them. HCI's "find a provider" tab located on our website has search engines to help members find health care. Members can select on the "Find a PCP" link to find a doctor, hospital, specialist, pharmacist, or LTSS specialist. Members can select "find a behavioral health provider" to find behavioral	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health specialists. Members can select "find a dentist" to be linked with Dentaquest, the agency that oversees Health First Colorado's dental benefits. Many of HCI members choose to contact our call center to request assistance in finding a provider in their vicinity. HCI's clinical service Assistants (CSA) use Beacon's referral connect system to narrow the search for a provider based on the member preferences. CSAs can search by: • The gender of the provider • The number of miles the provider lives from the member's home • If the provider is bilingual, including ASL • The ethnicity of the provider • Provider specialty including SUD specialty • Access for disabilities Members may ask a CSA if there is specialized equipment for their disability. If this occurs, the CSA will outreach the provider to ascertain if the provider can accommodate a disability.	
15. Provider directories are made available on the RAE's website in a machine-readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit B6—7.3.9.1.8	**Documents Submitted/Location Within Documents:** 1.Provider Directory_HCI – entire document 2. IT302.5_508ComplianceofExternalWebSitesPolicy_HCI, pages 2-3 3. WebsiteComplianceCheck_HCI, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Description of Process: HCI makes our provider directory available to members on our website in a machine-readable file and format. See https://s18637.pcdn.co/wp-content/uploads/sites/26/Provider-Directory-Health-Colorado.pdf. See Provider Directory_HCI, entire document. HCI has delegated website functions to Beacon. Beacon follows IT302.5_508ComplianceofExternalWebSitesPolicy_HCI to ensure that documents are machine-readable. The policy prioritizes any issues, which impede the website being accessible. Beacon runs 508/WCAG website scans monthly to resolve accessibility issues. The 508/WCAG reports is reviewed by a Beacon staff member to resolve and remediate any issues. The PR team completes a 508-accessibility check on the provider directory before uploading the PDF document to the website. See IT302.5_508ComplianceofExternalWebSitesPolicy_HCI, pages 2-3 and WebsiteComplianceCheck_HCI, entire document.	
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that include all of the following: • The RAE's single toll-free customer service phone number. • The RAE's email address.	**Documents Submitted/Location Within Documents:** 1. Brochure_HCI entire document, entire document 2. Cover Sheet_HCI, entire document 3. Constant Contact For New Members_HCI, entire document 4. YOM_Data_All_211220_HCI, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction.	5. YOM_Data_All_211220_Spanish_HCI, entire document 6. CAHPS_HCI, entire document **Description of Process:** HCI has developed materials to distribute to newly enrolled and existing members. All of the materials are on our website and can be printed out upon member request free of charge. See https://www.healthcoloradorae.com/members/new-member-welcome-packet/. HCI has printed out brochures to distribute to members. See Brochure_HCI, entire document. All of the required elements are located in the following locations: • HCI's single toll free customer service phone number, state relay number and email address are listed in the brochure and on the website. The phone numbers can be found in the top bar of the website – left side. The phone numbers and email address can be found by clicking the contact tab. See https://www.healthcoloradorae.com/contact/. • HCI's website address can be found in the brochure and on our cover sheet, which goes out with correspondence. See Brochure_HCI, entire document and Cover Sheet_HCI, entire document. • The basic features of a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP); the service area HCI covers; the requirement of HCI to provide adequate access to behavioral health services included in the plan including network	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 7: Exhibit B6—7.3.6.1	adequacy standards; and HCI's responsibility for coordination of member care are found on the About tab on the website. See https://www.healthcoloradorae.com/about/what-is-a-rae/ • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative can be found on our website under the News tab. See: https://www.healthcoloradorae.com/news/member-attribution/ • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit; information about where and how to obtain counseling and referral services that HCI does not cover because of moral or religious objections, and if there are any restrictions on the member's freedom of choice among network providers can be found on our website under the Member tab at: https://www.healthcoloradorae.com/members/benefits-and-services/ HCI encourages members to participate in a member satisfaction survey. See Want to Improve Your Health? on the main page of the website: https://www.healthcoloradorae.com. The quality team summarizes the member satisfaction survey results and uploads these results as well as other quality and performance indicators on the Provider tab of our website. See https://www.healthcoloradorae.com/providers/quality/.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. In an effort to increase the response rate for the Your Opinion Matters survey, HCI formed a work group to create a new distribution format for the survey. A publication advertising the survey was created. This publication was translated into Spanish in order to reach our Spanish Speaking population. Within the publication, HCI included a QR code. The use of a QR code was a recommendation that came from a member at the MEAC meeting. It was determined that this modality made access of the survey easier for our members. The publication will be placed on our social media sites. In addition, a Welltok text campaign will be launched. The aim of the campaign will be another option to reach members and to increase the survey response rates. The effort was successful. The outreach program generated four (4) responses in Spanish and 279 responses in English. See, YOM_Data_All_211220_HCI and YOM_Data_All_211220_Spanish_HCI. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results were evaluated and formatted for presentation and review. HCI has identified interventions that can increase satisfaction scores on future survey results by working directly with one of the facilities included in the survey. See CAHPS_HCI. This document details the activities taking place with providers to enhance CAHPS results.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: HCI used the Department's welcome letter and the *Health First Colorado Member Handbook* to inform newly enrolled members about services and to meet the requirements of 42 CFR §438.10. Although the welcome letter pointed members to the *Health First Colorado Member Handbook*, which included nearly all required information, the welcome letter distributed by the Department during CY 2021 did not contain HCI's website address and neither did the *Health First Colorado Member Handbook*. Based on additional evidence in the form of email communications between HCI and the Department in July and November 2021, HCI was under the impression that the welcome letter used throughout FY 2021 contained website address details for each managed care entity. Based on this information, the requirement is considered met. The Department reported that an updated letter that will include the RAE's website address is estimated to go into production in July 2022; therefore, no required action associated with this finding is needed.		
17. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 7: Exhibit B6—None	**Documents Submitted/Location Within Documents:** 1. HCPFWelcomeLtr_HCI, entire document *Misc. 2. Texting Scripts_HCI, entire document *Misc. 3. Cover Sheet_HCI, entire document 4. Brochure_HCI, entire document 5. EmailAddressReport_HCI, entire document 6. Constant Contact For New Members_HCI, entire document 7. Getting Started Flyer_HCI, entire document *Misc. 8. DHS PPT_HCI, slide 9 9. Provider Newsletter_HCI, page 2 *Misc. 10. Getting Started PPT_HCI, entire document *Misc. 11. Call Center Training_HCI, entire document 12. Welltok Monthly Report_HCI, entire document **Description of Process**: HCI provides member information through a variety of platforms. The predominant method is through our website,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.healthcoloradorae.com. The website has information about how members with disabilities are able to access the information online and explains how members will be provided auxiliary aids at no cost to them. HCI has worked with HCPF leadership to include our website URL address on their welcome letter to new members. For an example of the website address on the new member welcome letter, See HCPFWelcomeLtr_HCI, entire document. HCI employs texting technology through Welltok to alert members of our website address. HCI sends texts with website information through two campaigns -- welcome message and website link information. Members would be able to access member information through our website. Please see Texting Scripts_HCI and Welltok Monthly Report_HCI. HCI attaches a cover sheet to all of our correspondence that provides our website link. The cover sheet has taglines alerting members of the availability of auxiliary aids at no cost to them. HCI's website address is also located on our brochure where members can access member information on our website. See Cover Sheet_HCI and Brochure_HCI. HCI has started to obtain members' email addresses and consent when they call into the call center. The call center staff informs members that the email is to send them health information. HCI developed a monthly report to document the members that have consented to use their email address.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	See EmailAddressReport_HCI, entire document. For an example of an email sent to members, see Constant Contact For New Members_HCI. HCI identified that the first point of contact for newly enrolled members are the eligibility technicians at the Department of Human Services (DHS) offices. HCI's member engagement team has been meeting with the eligibility technicians in our nineteen (19) counties on a quarterly basis to leverage those relationships. The member engagement team provides eligibility technicians with information that they can give to our members. This information includes our brochure and a "getting started" flyer. The flyer has our website information, information on how to request help in other languages and a QR code to direct members to the new member welcome packet located on our website. The getting started flyer is also distributed in the provider newsletter. See Getting Started Flyer_HCI, Brochure_HCI, DHS PPT_HCI, slide 9, and Provider Newsletter_HCI, page 2. HCI's member engagement team goes over member information including benefit updates and services available to the member. For an example of member information reviewed with our members, see Getting Started PPT_HCI, entire document. HCI provides an annual training to the call center team to keep them informed of the information available to members on the website. The call center team can help connect	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members with the information found on the website. See Call Center Training_HCI, entire document.	
18. The RAE must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 7: Exhibit B6—None	HCI does not have any physician incentive plans currently in place.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	86%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the American Association of Pediatrics "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation. Contract Amendment 7: Exhibit B6—7.3.12.1, 7.6.2	**Documents Submitted/Location with Documents:** 1. HCPF EPSDT Email_HCI, entire document 2. EPSDT Weekly.csvlist_HCI, entire document 3. EPSDT Non-UtilizersReport_HCI, entire document 4. Texting Scripts_HCI, entire document *Misc. 5. WellVisitsTipSheet_HCI, entire document 6. EPSDT Tip Sheet_HCI, entire document 7. EPSDT Quarterly Report_HCI, entire document **Description of Process:** HCI onboards and informs members and their families about the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). HCI's Information Technology (IT) department receives a weekly EPSDT eligibility email stating that the eligibility files are ready from Healthcare Policy, and Financing (HCPF) department. This report contains all newly enrolled EPSDT eligible Medicaid members or those who regained eligibility after a twelve (12) month period of ineligibility and those members that have been identified as pregnant within the last sixty (60) days. Beacon's IT department downloads the member information from HCPF's weekly report and sends this information to Beacon's Data Analytic Reporting Team (DART). DART sorts the member data by language	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	preference -- English and Spanish, which are the languages for the majority of our members, and removes duplicate phone numbers so that only one identified household is contacted, although there may be several members residing in the one household. DART creates and sends a .csv file to HCI's member engagement team who is responsible to set up our first outreach to the member. HCI's first outreach is an interactive voice response (IVR) automated call to outreach members and family members, which is well within the first sixty (60) days of enrollment. This is a bi-directional outreach approach as members have the option to speak to a call center staff member in real time or are provided with HCI's call back number. HCI also has a texting campaign for newly enrolled members, which has been used to onboard and inform members about their benefits. See HCPF EPSDT Email_HCI, entire document, EPSDT Weekly.csvlist_HCI, entire document and Texting Scripts_HCI, entire document. HCI developed an automated monthly report to identify non-utilizing EPSDT eligible members that have not had a well visit within the past year. Those identified on this report are sent a text message notifying members that they are due for a well visit. Members are instructed to contact HCI's toll-free number if they need assistance with these appointments such as scheduling or transportation. See Non-UtilizersReport_HCI, entire document and Texting Scripts_HCI, entire document.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI has EPSDT resources on our website with a link to Bright Futures Guidelines. The Bright Futures Guidelines lists the American Academy of Pediatrics recommendations for preventive care. See: https://www.healthcoloradorae.com/members/new-member-welcome-packet/. HCI developed a well visit tip sheet, which has Bright Future guidelines on how frequently members need a well visit and what members should expect at their well visit (see WellVisitTipSheet_HCI). HCI also developed an EPSDT tip sheet with information about the benefits of preventive health care, the services available under EPSDT, and where and how members can obtain services. The tip sheet includes links to the American Association of Pediatrics' Bright Futures Guidelines. The EPSDT tip sheet includes information that services are without cost to the member and provides a phone number if members have questions or need to request transportation. Both tip sheets are located on our website. See https://www.healthcoloradorae.com/members/my-health-matters/ for the well visit tip sheet and https://www.healthcoloradorae.com/members/new-member-welcome-packet/ for the EPSDT tip sheet. See EPSDT Tip Sheet_HCI, entire document. HCI submits an EPSDT quarterly report to HCPF to reflect the work we have done in the previous quarter with outreaching newly eligible members and non-	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	utilizing EPSDT members. Newly eligible members are those under 21 years of age or pregnant females. Non-utilizing members are those who have not had a well visit in the previous twelve (12) months. The report contains a breakdown of outreach attempts and the success of each outreach attempt. The file is accompanied by a .csv file with the specific members who were outreached. Please See EPSDT Quarterly Report_HCI, entire document.	
Findings: Although HCI generally informed the member of general EPSDT information, the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, HCI did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately one in every five members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021.		
Required Actions: HCI must: • Update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits. • Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.		
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services:	**Documents Submitted/Location with Documents:** 1. EPSDT AnnualPlan_HCI, entire document 2. HCPFWelcomeLtr_HCI, entire document *Misc. 3. EPSDT Tip Sheet_HCI, entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 7: Exhibit B6—7.6.3.2	4. Provider Newsletter_HCI, page 3*Misc. 5. Getting Started Flyer_HCI, entire document *Misc. 6. Getting Started PPT_HCI, slide 11 *Misc. 7. Provider Documentation Training_HCI, slide 18 *Misc. 8. EPSDT Quarterly Report_HCI, page 2 **Description of Process:** HCI employs various methods of communication to outreach identified members that are eligible for the EPSDT program. HCI's goal is to ensure that our members are receiving regularly scheduled well visits and understand the benefits available to them for free such as physical health, behavioral health, vision, and dental services. HCI outlined their strategy for EPSDT outreach efforts in their annual plan submitted and accepted by HCPF. See EPSDT AnnualPlan_HCI, entire document. The plan outlines the variety of approaches HCI uses such as: <u>Mailed Letters</u>: HCI worked with HCPF to include our new member welcome packet link in the welcome letter that HCPF sends to new members. HCPF lists the RAE's phone number and HCI's website link, which would direct a member to HCI's new member welcome packet. See	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	https://www.healthcoloradorae.com/members/new-member-welcome-packet//. The purpose of this collaboration between HCI and HCPF was to consolidate information being sent to members. See HCPFWelcomeLtr_HCI, entire document. Face-to-face interactions HCI developed an EPSDT tip sheet with information about the benefits of preventive health care, the services available under EPSDT, and where and how members can obtain services. The tip sheet explains the available physical and behavioral services, which are covered for members at no charge to them. HCI distributes this tip sheet to care coordinators, DHS eligibility technicians, and practice transformation coaches. HCI's care coordinators and DHS eligibility technicians have face-to-face contact with our members. HCI's practice transformation coaches meet regularly with PCMP practices and distribute the EPSDT tip sheets to PCMPs who meet face-to-face with our members. HCI educates delegated staff members such as care coordinators on EPSDT benefits to leverage the relationships they have with our members. The PR team includes EPSDT information in the provider newsletters and educates providers at either roundtables or documentation trainings of member's EPSDT benefits. The tip sheet is located on our website. See https://www.healthcoloradorae.com/members/new-member-welcome-packet/. See EPSDT Tip Sheet_HCI,	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	entire document. See Provider Newsletter_HCI, page 3 and Provider Documentation Training_HCI, Slide 18. Telephonic, automated calls, Emails and Texting HCI uses both telephonic and automated calls to outreach members. When a member receives an automated call through our Interactive Voice Response (IVR) system, they have the option to speak with an HCI call center associate who can help answer any questions related to their health or EPSDT benefits or they can choose to call back at a time convenient for them. HCI sends text messages to new members and invites them to join our text messaging service to learn about their health benefits. Video conferencing HCI hosts a getting started webinar on the first Thursday of each month and uses ZOOM technology to explain benefits (including EPSDT) available to members. See Getting Started PPT_HCI, slide 11, Getting Started Flyer_HCI, entire document.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 7: Exhibit B6—7.6.2.3, 12.8.3.4; 12.9.3.4	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy_HCI, page 5 2. ProviderDocumentationTrainingInvite_HCI, entire document 3. Provider Documentation Training_HCI, slide 18 *Misc. 4. BehavioralHealthProviderHandbook_HCI, pages 38-40*Misc. 5. ChartAuditTool_HCI, entire document*Misc. **Description of Process:** HCI offers training for network providers to increase awareness of Health First Colorado's EPSDT program information. HCI follows our 248L_EPSDTPolicy, which outlines our procedures for oversight of the EPSDT program, including education for our providers. See 248l_EPSDTPolicy_HCI, page 5. HCI's Quality Department also provides documentation training for providers on a quarterly basis. The training reviews the EPSDT benefit and documentation requirements for providers. Dates of training were March 11, 2021, June 21, 2021, September 30, 2021 and December 10, 2021. See ProviderDocumentationTrainingInvite_HCI and Provider Documentation Training_HCI, slide 18.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI offered a PCMP Roundtable in August 2021 and reviewed EPSDT benefits. The slide presentation can be found on our website at: https://www.healthcoloradorae.com/hci-august-primary-care-provider-support-call/, slides 8-15. HCI outlines EPSDT benefits and includes HCPF's information in the provider handbook. The handbook outlines providers' responsibility for the following: • Assess new members to determine that EPSDT screenings have been occurring (page 67). • Refer members to their PCP, if screenings are not being conducted (page 67). • Provide behavioral health assessment/treatment upon referral from a PCP who desires additional behavioral health services, and for which medical necessity has been determined (page 67). • Communicate with the PCP regarding any pertinent findings/actions (page 67). • Document all actions in the member's clinical record (page 68). See BehavioralHealthProviderHandbook_HCI, pages 38-40 which can also be found on our website. See https://s18637.pcdn.co/wp-content/uploads/sites/26/CO-Behavioral-Health-Medicaid-Provider-Handbook.pdf.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's Quality Department completes chart audits for our contracted providers. The Quality Department reviews member charts to ascertain if providers have documented evidence that they educated the child/parent about EPSDT services needed. See ChartAuditTool_HCI, entire document, line #73. HCI's quality team sends a letter with chart audit results to the provider, noting any missing documentation and offers assistance to help providers meet Health First Colorado's standards for documentation.	
4. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). For the *Capitated Behavioral Health Benefit*, the RAE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services.	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy_HCI-Entire Policy 2. BehavioralHealthProviderHandbook_HCI, pages 38-40 *Misc. 3. Provider Documentation Training_HCI, slide 18 *Misc. 4. ChartAuditTool_HCI, entire document. *Misc. **Description of Process:** HCI provides or arranges for the provision of all medically necessary capitated behavioral health benefit coverage for members under the age of twenty-one (21). HCI has a written policy and procedure related to the EPSDT program and its requirements, which we follow.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	See 248L_EPSDTPolicy_HCI, entire document. The policy outlines: • That eligibility for the EPSDT benefits is for any member enrolled in the Health First Colorado who is 20 years old or younger (page 2) • The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered (page 5) • HCI authorizes all medically necessary services covered by the capitated benefit program (page 6) • The RAE reviews all requests for mental and behavioral health developmental screenings to eligible EPSDT members or family members who request it. The RAE will ensure these screenings are performed by a provider qualified (correct licensure) to furnish mental health screenings in a culturally and linguistically sensitive manner (page 6). • The RAE shall authorize diagnostic services and treat any identified diagnostic or treatment	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	service needs; including substance abuse needs, which are medically necessary (page 6). HCI's contract network providers are instructed about the documentation requirement through the provider handbook and the documentation training provided by HCI's quality department. HCI's quality team also completed chart audits for our contracted providers to ensure that they are documenting that they discussed EPSDT services with members. This information is recorded in the chart audit tool. HCI did not have any major concerns regarding EPSDT documentation from provider charts which were edited. See BehavioralHealthProviderHandbook_HCI, pages 38-40, Provider Documentation Training_HCI, slide 18 and ChartAuditTool_HCI, line #74.	
5. *For the Capitated Behavioral Health Benefit,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program.	**Documents Submitted/Location Within Documents:** 1. BehavioralHealthProviderHandbook_HCI, Pages 38-40 *Misc. 2. 248L_EPSDTPolicy_HCI, entire policy 3. Care Coordination Fact Sheet_HCI, entire document *Misc. 4. Care Coordination Referral Form_HCI, entire document 5. ChartAuditTool_HCI, entire document *Misc. 6. CareCoordinationAuditTool_HCI, lines 36-43 *Misc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 441.61–62 Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.280.4.C	**Description of Process:** HCI provides referral assistance for treatment, which is not covered by the plan but is found to be needed as of a result of conditions disclosed during screening and diagnosis. HCI follows this requirement, which is outlined in our 248L_EPSDTPolicy_HCI, page 2. This policy also explains that HCI will help members and their families schedule transportation or appointments for any EPSDT related services One example of HCI providing referral assistance was for a member identified by a caseworker from the Department of Human Services (DHS). HCI was contacted by this caseworker to find out about covered benefits. In this situation, potentially adoptive parents were seeking a treatment for a non-covered service (acupuncture) to treat a child's epilepsy, which was identified during this child's screening. HCI's member engagement team set up a meeting with the DHS caseworker (legal guardian at the time) and the assigned a care coordinator to discuss options under EPSDT services. The care coordinator agreed to discuss this with the PCP to see if it may be covered under the child's EPSDT benefits. HCI's delegated care coordination agencies assist families and members with transportation and scheduling assistance as well as referrals to appropriate state health agencies as a general function of care coordination. HCI's delegated care coordination agencies are embedded in the communities through the	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	shareholder sites and delegated PCMP sites. HCI completes chart audits with our delegated care coordination agencies for evidence to support that care coordination activities such as transportation, scheduling assistance, and referrals to appropriate state health agencies has occurred. HCI sends a letter to care coordination agencies following an audit which outlines any missing information from a member's chart and offers assistance to help providers meet Health First Colorado's standards for documentation (see CareCoordinationAuditTool_HCI, lines 36-43). HCI developed a care coordination fact sheet, which helps members know about care coordination services (see Care Coordination Fact Sheet_HCI). The care coordination fact sheet is also available in the new member welcome packet on our website (see https://www.healthcoloradorae.com/members/new-member-welcome-packet/). The care coordination fact sheet has information about how to contact HCI's toll free number to request care coordination. When members contact HCI's call center, the call center team can make a referral to a care coordinator who helps the member set up appointments, schedule transportation, or link a member with a state health agency. The call center staff can help explain the care coordination benefit and will refer a member identified as needing care coordination services to the member's assigned care coordination agency (see; and Care Coordination Referral Form_HCI). The care coordination referral	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	form has multiple reasons that a member may be referred for care coordination services. Once the care coordination referral form is completely filled out, it is sent through a secure email system to the care coordination agency who acknowledges that they have received the form and will reach out to the member. If a call center associate does not receive a response back from the care coordination agency, they outreach the care coordination agency to ensure that the referral was received. HCI's makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. The RAE has allied with community and governmental agencies such as Community Centered Boards, Single Entry Point agencies, maternal and child health programs, Head Start, WIC, SNAP, vocational rehabilitation, and other organizations providing medically necessary services that are not covered under the capitated behavioral health benefit. HCI has many of these agency links on our website. This requirement is outlined in our 248L_EPSDT policy_HCI. See 248L_EPSDTPolicy_HCI, pages 7-8. Care Coordination Referral Form_HCI, entire document.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI's providers are also expected to coordinate with non-medical providers and social service agencies when appropriate. This is outlined in the provider handbook about offering the member and family with referral assistance, appointment scheduling and transportation services. HCI's quality team completes chart audits with our contract providers and looks for evidence that there is coordination with non-medical providers. See BehavioralHealthProviderHandbook_HCI, Pages 38-40 and ChartAuditTool_HCI, Line #75.	
6. *For the Capitated Behavioral Health Benefit*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration.	**Documents Submitted/Location Within Documents:** 1. 248L_EPSDTPolicy_HCI, entire document 2. CCM Agenda_HCI, entire document **Description of Process**: HCI outlines the definition of medical necessity for EPSDT services in our 248L_EPSDT policy_HCI for the capitated behavioral health benefit. The medical necessity definition is for a program, good, or service that: • Will or is reasonably be expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 7: Exhibit B6—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	a course of treatment that includes mere observation or no treatment at all (page 4). • Assists the member to achieve or maintain maximum functional capacity (page 4). • Is provided in accordance with generally accepted professional standards for health care in the United States (page 6). • Is clinically appropriate in terms of type, frequency, extent, site, and duration (page 6). • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider (page 6). • Is delivered in the most appropriate setting(s) required by the client's condition (page 6). • Provides a safe environment or situation for the child (page 6) • Is not experimental or investigational (page 6). • Is not more costly than other equally effective treatment options (page 4). HCI's delegates utilization management to Beacon Health Options. Beacon oversees all capitated behavioral health utilization and refers to the 248L_EPSDT policy_HCI for definitions of medical necessity for EPSDT services, goods or programs. The utilization management team reviews EPSDT medically necessary criteria at least annually during their regularly scheduled bi-weekly meeting. Please see CCM	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Agenda_HCI, entire document for evidence to support the review of medically necessary criteria.	
7. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 7: Exhibit B6—14.5.7.1, 2.1.1	**Documents Submitted/Location Within Documents:** 1. RTCReport_HCI, entire document 2. Encounter&ClaimReport_HCI, entire document 3. EvidenceofICMandCreativeSolutions Meeting_HCI, entire document **Description of Process:** HCI provides or arranges the following services for the capitated behavioral health benefit for children and youth ages 0-21: • Vocational Services. These services are usually arranged through HCI's care coordinators or HCI's community mental health centers who have vocational programs. • Intensive Case Management (ICM). These services are provided by an assigned intensive case manager or a care coordinator. ICMs attend HCPF-run Creative Solutions meetings. • Prevention/Early Intervention. These services are usually provided through our providers or the CMHCs. CPT codes include: S9453 S9454, H0022, H0023, H0024, H0025, H0027, H0028, H0029 • Clubhouse and drop-in centers: These services are available through our community mental	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health centers within our nineteen (19) counties. CPT codes include: CPT codes H0029, H2030, H2031 • Residential Care. These services are provided by contracted behavioral health provided when medically necessary. • Assertive Community Treatment (ACT). These services are usually provided through our providers or the CMHCs. CPT codes include: CPT codes H0039 and H0040. • Recovery Services. These services are provided through our providers or CMHCs. CPT codes include: H0043, H0044, H2015, H2016 • Respite Services. These services are usually provided through our providers or the CMHCs. CPT codes include T1005, T1006, and H0045. HCI pulled a report for the above-listed services, which we provide or arrange for under the capitated behavioral health benefit. This can be found in RTCReport_HCI, entire document and Encounter&ClaimReport_HCI, entire document. HCI participates in HCPF's Creative Solutions meetings to provide intensive case management and help arrange services for EPSDT-eligible members when appropriate. See EvidenceofICMandCreativeSolutions Meeting_HCI, entire document.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	HCI refer members to community center boards for assessment of services provided in the 1915 (b) (3) waiver services. HCI's member services director attends both the Children's Disability Advisory Committee (CDAC) and HCPF's Children's Services Steering Committee. The goal of HCI's participation in these meetings is to inform committee members who work with EPSDT eligible members about the services HCI can provide and/or arrange.	

Results for Standard XI—EPSDT Services							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	86%

Appendix B. Site Review Participants

Table B-1 lists the participants in the FY 2021–2022 site review of **HCI**.

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Evarista Ogbon	Project Manager I
Sara Dixon	Project Manager II
Lauren Gomez	Project Manager I
Crystal Brown	Project Coordinator III
HCI Participants	**Title**
Alicia Williams	Chief Operating Officer
Alma Mejorado	Director, Contracting Development
Cathy Michopoulos	Chief Operations Officer
Charlotte Blakely-Frazier	Privacy and Security Consultant
Courtney Hernandez	Behavioral Health Clinical Quality Analyst, Senior
Dawn Surface	Member Engagement Specialist
Dr. Brian Hill	Chief Clinical Officer
Ed Arnold	Performance Improvement Analyst
Jamie Coahran	Contract Development Manager
Jen Wang	Web User Interface Developer
Jeremy White	Quality Program Manager
John Mahalik	Director of Quality Management
Jonathan Lopez	Corp Privacy Compliance Analyst I, Beacon Compliance
Karen Talone	Colorado Provider Relations Manager
Kristi Williams	Compliance Manager
Laura Natale	Privacy Compliance Analyst
Lori Roberts	Chief Executive Officer/Program Officer
Lori Sealock	Call Center Manager
Lynne Bakalyan	Director, Member Services
Michael Clark	Director of Health Information Systems
Myron Unruh	Beacon Market President
Randi Addington	Director of Contract Compliance & Program Innovation

HCI Participants	Title
Ron Botten	Director of Information Technology
Sheree Marzka	Director II, Compliance
Dr. Steve Coen	Director of Utilization Management
Tina Gonzalez	Health Promotion Consult Senior
Tina McCrory	Chief Strategy Officer
Department Observers	**Title**
Angela Ukoha	Accountable Care Collaborative Program Specialist
Brooke Powers	Accountable Care Collaborative Program Specialist
Curt Curnow	Quality Improvement Section Manager
Erin Herman	Health Programs Office, Program Administrator
Gina Robinson	Program Administrator
Russell Kennedy	Quality and Compliance Specialist

Appendix C. Corrective Action Plan Template for FY 2021–2022

If applicable, the health plan 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 health plan 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 health plan must submit documents based on the approved timeline.

Table C-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan 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 health plan 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 health plan to proceed with implementation, or • Instruct the health plan 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 health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan 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 health plan 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 health plan within the intervening time frame.) If the health plan 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 health plan'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 health plan's discretion at any time the health plan 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 health plan 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 health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table C-2—FY 2021–2022 Corrective Action Plan for HCI

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
4. The RAE makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (conspicuously-visible font size) and prevalent non-English languages describing how to request auxiliary aids and	The *Member Information Requirements* policy described procedures for ensuring that member informational materials contain taglines that are consistent with the member information requirements. However, some critical member materials did not include all required components of a tagline. • The cover sheet, welcome letter, and provider directory had taglines but did not have the entire tagline translated in Spanish. • The newly pregnant member welcome letter, *HCI Brochure*, *Getting Started Flyer*, *Getting Started Pregnancy Guide*, *EPSDT Tip Sheet*, welcome letter, and *Care Coordination Fact Sheet* did not have a tagline in English and Spanish.	HCI must revise critical member materials to include all required components of a tagline.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
services, including written translation or oral interpretation and the toll-free and TTY/TDD customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 7: Exhibit B6—7.2.7.3–9; 7.3.13.3		
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:		
HSAG Initial Review:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Documents for Final Submission:		
Date of Final Evidence:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. • Provide a link to the Department's website on the RAE's website for standardized information such as member rights and handbooks. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B6—7.3.14.1, 7.3.9.2	During the review, staff members reported that HCI received minimal ad hoc printing requests. Although HCI submitted an email as evidence to show how HCI communicates internally to fulfill such requests, HCI could not provide supporting documents to demonstrate how HCI monitors the five-day requirements for such requests. HCI reported an opportunity to begin using an MS Excel tracking mechanism to document timely mailing of ad hoc printing requests. HCI's general member webpage and provider directory webpage included a statement that materials can be printed but did not include "within five business days." HSAG recommends that, as best practice, the full statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page).	HCI must develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
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:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
1. The RAE onboards and informs members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the RAE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the American Association of Pediatrics "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost	Although HCI generally informed the member of general EPSDT information, the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, HCI did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately one in every five members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021.	HCI must: • Update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits. • Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Findings**	**Required Action**
to the member, and how to request transportation. Contract Amendment 7: Exhibit B6—7.3.12.1, 7.6.2		
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:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix D. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop 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 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 review dates, group technical assistance and training, as needed. • HSAG confirmed a primary RAE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and review activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the 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 HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the 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 review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft 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.